the MODERN HOSPITAL

VOLUME 59 JULY 1942 NUMBER 1

In Surgical Shock

peripheral vascular failure may be corrected

without appreciable nervous stimulation with low toxicity

Neo-Synephrin

Hydrochloride

(laevo—alpha—hydroxy—beta—methyl—amino—3 hydroxy ethylbenzene hydrochloride)

Supplied in 1 c.c. ampules, and in rubber-capped vials containing 5 c.c. of a sterile 1% solution. Average subcutaneous dose: 0.5 c.c.

Frederick Stearns & Company

Since 1855 . . . ESSENTIALS OF THE PHYSICIAN'S ARMAMENTARIUM

NEW YORK KANSAS CITY SAN FRANCISCO WINDSOR, ONTARIO **DETROIT, MICH.** SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

CONTENTS

For July 1942

Just in Passing—

EVEN the medical record department can participate significantly in war-time economies while maintaining efficiency, according to Sister Mary Patricia of St. Mary's Hospital, Duluth, who from her broad knowledge discusses the subject in next month's issue.

NEW JERSEY hospitals are now seriously attempting to do something effective about their accounting. The program is described next month by Emil J. Frankel.

ANOTHER important war activity that is also valuable for peace centers around the National Nutrition Program. Its implications for hospitals will be presented next month.

AN IMPORTANT advance in sterilizing instruments will be presented next month. Definite economies in time, materials and expense are suggested.

for BETTER STAFF WORK

Your department heads need information in this issue. You can call it to their attention easily with the coupon below. Just tear it out and paste or clip to the cover of the magazine.

READ AND PASS ALONG

	See page Noted
Purch. Agent	
Supt. of Nurses	
Surg. Supervisor	
Dietitian	
Housekeeper	
Pharmacist	
Engineer	
Laundry Manager	
Radiologist	
Pathologist	
Chief of Staff	

Return to

The Modern Hospital

Published monthly and copyrighted, 1942, The Modern Hospital Publishing Company, Inc., 919 N. Michigan Ave., Chicago. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U.S.A.

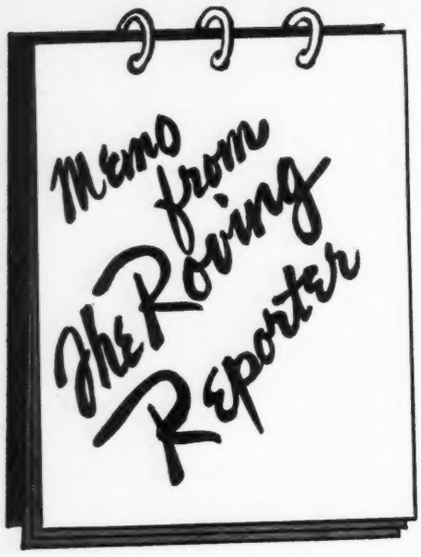
Diethylstilbestrol

(Formerly Known as Stilbestrol)

★ Diethylstilbestrol, a crystalline synthetic estrogen, is of particular value in relieving symptoms of the menopause and in treating senile and gonorrheal vaginitis. Diethylstilbestrol also can relieve or prevent painful engorgement of the breasts during suppression of lactation. It is effective when administered orally and rarely causes gastrointestinal side-effects. Supplied in Tablets, Ampoules, and Suppositories. Comprehensive literature is available to members of the medical and pharmaceutical professions.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.



Good Will Via Radio

The local radio station usually is susceptible to friendly advances on the part of the community hospital and often a lasting tie-up can be arranged. One of the most successful of these working relationships may be found at Ironwood, Mich. There the Gogebic County hospital, known as Grand View Hospital, is on the air daily with its "Cheer-'Em-Up" program.

It all started more than six years ago when hospital and radio station joined hands on a half hour daily broadcast in which friends and relatives sent in requests for musical numbers that they believed their loved ones in the hospital would like to hear.

So successful was the program and so numerous became the requests on the radio station that, in conjunction with the hospital, the station made the program general and permanent, serving home as well as hospital patients on the Cheer-'Em-Up hour.

To show how much good will can be derived from such a source, J. A. Blaha, the hospital's business manager, relates the following incident. The radio station, in collaboration with the Nurses' Association of Gogebic County, some time ago started a campaign for funds for an incubator for the hospital. The campaign was oversubscribed to the extent that the hospital was able to build a new nursery and to purchase needed nursery equipment.

Every Saturday morning the hospital's follow-up worker on tuberculous cases (the hospital has a tuberculosis department) gives the radio public information on tuberculosis; other staff members educate the public on health problems. A week or ten days before National Hospital Day each year Mr. Blaha is on the air for fifteen minutes daily, telling the public of hospital service and hospital problems.

Any institution so public relations conscious as Grand View also has cordial working arrangements with the local press. But that is another story.

• •

Rental Service for Home Patients

One hospital in every town might well consider a rental service for sickroom supplies to service patients who are sick or convalescing at home. Some hospital and bedside equipment is much too expensive for the average family to buy; therefore, it becomes more feasible to rent.

Berkeley Hospital, Berkeley, Calif., has a sickroom rental supply service that is fairly comprehensive. Several new pieces of equipment have recently been added to improve the service. Alfred E. Maffley, the superintendent, presents a list that well may serve as a standard for other hospitals supplying or contemplating starting such a rental service. Here is what Berkeley Hospital has provided its public at reasonable rental charges:

Hospital beds	Back rests
Fracture beds	Bedside tables
Crank beds	Wheel chairs
Folding bed cradles	Invalid walkers
Commodes	Splints
Bed sides	Miscellaneous bedside equipment
Balkan frames	
Bradford frames	

• •

Introducing Mrs. Moore

She is, believe it or not, the personal shopper for 4000 hospitalized men and women in the Colorado State Hospital at Pueblo. Money sent to patients by relatives and friends is kept in the hospital steward's patient fund and the patient may spend up to one dollar each week by writing an order on his account. If he wants to spend more he must have the written approval of the assistant superintendent. Whether the amount is one cent or one dollar, it is Mrs. Moore's job to help the patient get the article or articles desired.

This personalized shopping service was inaugurated almost five years ago by Dr. F. H. Zimmerman, superintendent of the hospital, to make the patients feel that someone had a personal interest in them. It was decided that they should have the fun and satisfaction of spending their own money and getting what they want. And their wants range from thread, gum, shoe laces, cards, peanuts, clothing, handkerchiefs and cosmetics to, yes, defense stamps.

Sunday afternoon finds the patients making out their lists. These reach Mrs. Moore on Monday, whereupon she gets busy checking the orders and visiting the stores so that deliveries will be ready by Saturday. It is done leisurely and efficiently.

Sometimes patients are able to accompany Mrs. Moore on her shopping expeditions. If so, they are taken in groups of two and three. Occasionally a woman patient will want a permanent wave or someone will need to have glasses fitted. Mrs. Moore is glad to serve as personal escort.

When she is not thus engaged, Mrs. Moore is discovered supervising incoming packages by mail. Each one is opened and identified with the patient's name. Anything that might be harmful is removed; all items are listed and an acknowledgment is mailed to the sender. Seven women assist Mrs. Moore in this work.

The service brings great happiness to the patients. "They read the newspaper advertisements carefully," Mrs. Moore tells us, "and take advantage of any bargains that are offered."

"And can they make money stretch!" she adds.

• •

That All May Know

Another hospital tells the story of its contribution to medical science through the years! This time it's Mount Sinai of New York, which, to mark its ninetieth anniversary, has staged an exhibit for the public illustrating its many scientific achievements. Judging from the interested spectators who made the rounds with your Roving Reporter, a good attendance is assured for the duration of the "run."

The story is told in two sections, historical and scientific. Let's make a quick inspection starting with the historical exhibit. What an impressive collection of records, and surely there could be no better demonstration of the institution's high medical attainments than the numbers of decorations bestowed upon former and present members of the staff! How curious are some of those old surgical instruments used during the Civil War period!

Before nostalgia overcomes us completely, we will pass along to the scientific exhibit. Here are copies of books on medicine and surgery written by members of the staff with exhibits portraying research into methods of blood transfusion and the establishment of blood banks, the results of studies in the cure of syphilis, nutrition in war time, studies in sex hormones and many more too numerous to mention.

But a hospital doesn't need to wait for its ninetieth birthday to tell its story. The sooner the better to inform people generally of the medical research that goes on under voluntary auspices.

LOOKING FORWARD

New Openings in the Hospital

THE present manpower shortage that is harassing hospital administrators so greatly will, perhaps, open the door of opportunity to certain groups heretofore more or less neglected.

In replacing men who have gone to the armed services or war industries, hospitals are turning their attention to four other sources of personnel: women, Negroes, conscientious objectors and the physically handicapped.

As regards women, Dr. Charles C. Burlingame, administrator of the Neuro-Psychiatric Institute in Hartford, Conn., recently declared that, while women have long played an important executive rôle in hospital administration, the time has come "to dignify the movement already in full swing by giving full and complete responsibility throughout the hospital to women of proven ability. There is nothing inherently weak about a woman's intellectual or her emotional drives. In the field of our immediate necessity, there is probably nothing that woman cannot do equally well if not better than man, if she is in a frame of mind to attempt it."

And this from a man!

Many American hospitals in both the North and the South have long employed Negroes in various capacities. Often only menial positions have been open to this tenth part of our population. But in the seventy-nine years since the Emancipation Proclamation there have been slow but continuing advances in the education of American Negroes. Now many of them are qualified for more responsible positions in hospital work. War-time needs of hospitals may make them look more carefully into the possibilities in this direction.

The possibilities of using the service of religious conscientious objectors was mentioned briefly in these columns last month. Any hospitals that are interested in following up on this possibility should get in touch with the National Service Board for Religious Objectors in Washington, D. C. (1751 N. Street, N.W.) and the officials of the Selective Service System. One Chicago hospital that is using 30 of these men reports that they are very satisfactory; in fact, that they have been "life savers." Other hospitals fear that their use would result in public criticism.

Finally, industry is finding many uses for persons handicapped by crippling conditions, heart defects, healed tuberculous lesions, deafness and even eye defects.

As the need becomes greater to make more able-bodied men available for the armed services and the war industries, each hospital should survey its job qualifications to see what jobs can be eliminated and what jobs now employing able-bodied men can be filled from other sources.

Conservation Begins at Home

IT IS a favorite pastime for those who wish to sabotage the present national effort and to raise doubts as to the nation's leadership to point out inconsistencies in federal activities and unfairness in the application of federal rulings. Because of the enormous size of our present task and the speed that is necessary, inconsistencies and unfairness are bound to exist.

Without any intention of indulging in carping criticism but rather to point out to government officials the importance of seeing that their policies are carried out all the way down the line, certain facts can be mentioned.

Civilian hospitals are rapidly being deprived of more and more types of equipment, particularly those that consume metal and rubber. This is as it should be. Such scarce materials should be conserved for the essential needs of the armed services.

But the civilian hospitals will accept their deprivations in better spirit if the hospitals of the Army, Navy and Marine Corps, which have an A-1-a priority rating, will not needlessly consume supplies of stainless steel, chromium, rubber and other scarce materials. One does not visit with a group of manufacturers of hospital equipment for more than a few minutes before he learns of the large orders, still based on prewar specifications, that are placed by these governmental hospitals. Somebody did a fine job before the war in selling the federal government on the need for the finest materials in sterilizers, necropsy tables and countless other items. Now the orders come through without any change in

specifications, even though noncritical and acceptable substitutes may be readily available.

If there is time to take the matter up with the ranking officials in Washington, often the specifications can be changed. But the men in actual charge in the field are often unable or unwilling to take the responsibility of accepting substitutes or to allow time for an appeal to Washington.

The armed forces and the War Production Board should now take whatever steps may be necessary to see that the conservation policies enforced on civilian hospitals are also applied, whenever possible, to their own purchases.

A New Hospital for Harlem

THE problem of providing adequate hospital service to Negroes and adequate educational opportunities for Negro physicians and nurses remains largely unsolved in the United States. True, many institutions are doing fine work in these fields but the unmet needs are still great.

It is good, therefore, to learn that many of the leading citizens of Harlem are joining hands to provide a new voluntary hospital for the Negroes of New York City. The district, containing a mixed population of about 400,000 people, has one municipal and two voluntary hospitals. But there is still a serious shortage of facilities for the Negro physicians of the area to use in caring for private patients.

Hospital care equal to that afforded to the whites of New York City should be available to the Negroes. Educational opportunities, likewise, should be equal. Racial discrimination in the United States and throughout the world should be one of the major casualties of this war.

Changing Intern Practices

WAR-TIME requirements have made necessary the revision of hospital internships and an intensification of medical courses throughout the country's hospitals and schools of medicine. The resulting problem of readjusting intern curriculums is difficult for hospitals generally. To complicate the situation further, as has been indicated, the Association of American Medical Colleges, at the urgent suggestion of federal authorities, has approved the shortening of vacations so that young physicians now will be graduated several months earlier than they were formerly.

Since most hospitals admit all of the members of the new intern class on or about July 1 of each year or accept these interns at intervals of three months throughout the year, hospital schedules must be radically readjusted. Students who formerly were available for internship on July 1, this year were graduated on May 1; eventually, as the plan progresses, interns will enter hospitals even several months earlier, since medical courses now will consume slightly more than three calendar years.

Because of the shortage of interns, because the hospital will need more interns each year and because of the intensification of medical courses, certain new factors enter the problem. Hospitals will find that they must carry on their work with many fewer interns. They will of necessity be required to arrange for such a flexibility of service that after young physicians receive their diplomas they will not be forced to wait from three to six months before beginning their internship. In urban communities some generally accepted method of appointing interns must be worked out so that businesslike and ethical procedures in obtaining them will be followed.

The hospital may well examine its intern curriculum as well as its general methods of caring for patients so as to determine whether some duties now assigned to interns may not be delegated to other staff members. Many institutions will be able to maintain standards of service with fewer interns. This reduction may approach 25 per cent. State boards of medical education are inclined to insist that interns be permitted on the ratio of beds occupied rather than on total hospital capacity; this will serve to increase the total number of interns available throughout the field while limiting the individual hospital.

Finally, the hospital, not only in intern matters but in other activities as well, will find that it can eliminate many of the refinements of record keeping and other similar paper work and still be able to furnish good care to the sick.

Knowing Where You Stand

A SIMPLE but important part of good administration and good personnel management is often overlooked in hospitals. This is the need for a reasonably clear and adequate definition of authority and responsibility for all members of the administrative and medical staffs.

While organization charts do not necessarily solve problems of organization, they do often bring them clearly to light when they exist. It is a healthy experience, therefore, for the administrator and his department heads to draw up organization charts for the entire hospital. A master chart can indicate the relations of each department to the administrator and to the other departments. Then individual charts for each department should be prepared and, if possible, posted in the department so that all employes may see just where they fit into the total picture.

While there are obvious dangers in too rigid and formal definition of duties and responsibilities, there are great advantages in having at least the main outlines clearly understood by all persons concerned. This suggestion, of course, is but one aspect of the well-known principle of administration, succinctly stated as "organize, deputize and supervise."

Let's Salvage and Conserve

to Accelerate the War Effort

E. W. MILLER

Chief Pharmacist and Chairman, Conservation and Salvage Committee

City Hospital of Akron, Akron, Ohio

SALVAGE and conservation are really synonymous. The first term means the diversion of used materials into channels of reprocessing; the second means the prevention of wasteful usage of new materials.

Both conditions increase the availability of supplies for an all-out war effort, which is our primary patriotic concern and which, in turn, will stem the rising cost of operation in the hospital generally.

To execute effectively a salvage and conservation program a definite plan of action must be established. Some one individual must be selected to be responsible for all phases of the campaign. This person must select key people from the various departments and professional staffs to meet periodically to discuss problems relative to the campaign.

Educate Personnel

An initial educational drive should be conducted to make the personnel conscious of what must be done and just how it can be done. Several persons who have artistic ability should be selected to make posters for display in prominent places. Bulletins may be distributed periodically or editorials may be run in hospital papers. The program may well be represented occasionally in the various professional staff meetings.

One of the primary objectives is to make every person in the institution feel that he is a part of a patriotic program. When this feeling of patriotism is aroused, everyone will cooperate to the fullest extent and definite steps may be taken to salvage waste and to conserve all scarce supplies.

To salvage waste, several factors must be seriously considered. A sanitary condition must be maintained at all times. Fire hazards must be prevented and careful consideration must be made of possible contaminated material. Every precaution must be made to keep a high standard of cleanliness and neatness and at the same time material must be accumulated so that it may be sold advantageously.

The greatest volume of waste from a hospital consists of paper. Paper should be separated into magazines, newspapers, cardboard and mixed paper and, if possible, the mixed paper should be baled for convenience in handling and storing. The recent shortage of paper was due to the increased demand for making cardboard boxes necessary for shipping war materials to the armed forces of this country as well as to other countries. Shells are enclosed in paper tubes to facilitate handling. Wood pulp, which is a raw material used in making paper, is used as an absorbent for liquid explosives in making shells.

Metal of all kinds is urgently needed for reprocessing. This material should be separated into the various types, such as copper, aluminum and brass.

Bones and fats can be salvaged from the dietary department and separated into rendered fat, raw fat or suet, cooked bones and raw bones. Each of these classifications commands a different price when sold. The mention of these items may sound insignificant to the average person, and possibly even to some people employed in our dietary departments, but they can contribute tremendously to our war effort.

Bones are processed to form fertilizers. They are a part of some poultry feeds. They are made to produce bone black, which is used in the processing of brown sugar to white sugar. Bone black also is used to put a hard case on steel. Bone buttons have been found to outlast other types and this fact is being recognized in making uniforms. Previous to our present emergency, most bone used in this country was imported from India and South America. Since these sources have been curtailed, we must depend on the salvage bones of this country to supply the demand.

Drive on for Fat and Oils

Animal fat and vegetable oils are used in the manufacture of soap. We need not mention the importance of soap to our armed forces, as well as for civilian use. Equally important is glycerin, a by-product of soap manufacture. Glycerin is used to manufacture nitroglycerin, an important explosive. There is a definite shortage of fats and oils in this country and the government is anticipating a drive to salvage the fats and oils from the kitchen of the American home.

Burlap sacks should be returned to venders for credit, it is urged.

Commodity Consumption

	January 1942	*February 1942*	*March 1942*
Rubber gloves	69 dozen	46 dozen	38 dozen
Ice caps	6 only	4 only	5 only
Hot water bottles	10 only	3 only	6 only

	1941			*1942*		
	Oct.	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*March*
Dressings						
4 by 4″ sponges, 16 ply	37	24	19	21	7	0
4 by 4″ sponges, 8 ply	0	0	0	1	9	25

Posters made by the personnel of City Hospital of Akron to further the salvage and conservation campaign.

Glass should be saved and separated according to color. The manufacture of new glass requires the use of approximately 17 per cent of old glass. Glass jars will be used to package foods owing to the acute scarcity of tin.

Green vegetable trimmings can be used in the animal house for feeding.

All cupboards and drawers should be inspected for materials that cannot be used and all broken equipment that cannot be repaired should be turned into the salvage effort.

When the personnel throughout the institution has become salvage conscious, they will, by the same token, begin to conserve supplies. Conservation is as important as salvage. The aim of every hospital

administrator, during peace time as well as war time, is the conservation of supplies, and this program may well continue after the present emergency is past.

Rubber is perishable and at the present time is possibly scarcer than any other raw material. The proper handling of rubber supplies will add considerably to their useful life. Everything must be done to avoid unnecessary replacement. Rubber materials should always be stored away from heat and light. The ideal storage temperature is about 50° F. It is claimed that the rate of deterioration of rubber goods doubles with every 20° F. rise in temperature.

Punctured water bottles, ice caps and invalid cushions must be repaired and placed in service immediately. Rubber gloves can be patched and used by everyone who assists the surgeon. Rubber fingers may be used in place of rubber gloves for rectal examinations. The patches used to repair gloves may be obtained from gloves that are beyond repair. These patches then should be applied with a good quality of rubber cement. Oil or grease should be removed from rubber articles with soap and water.

The armed forces have first call on surgical dressings. The combined demand for dressing for war use, for civilian defense and for hospital use will strain the production facilities of the entire dressing industry. Therefore, it is our solemn obligation to keep these supplies available. Eight ply sponges may be used instead of 16 ply sponges. Three by 3 inch sponges may be used instead of 4 by 4 inch sponges, and so on through the various sizes. Staff members may be consulted in regard to the use of less dressing on patients.

In some instances, suturing material is broken open as a routine procedure previous to operation; possibly a great amount of this material is unused and discarded. The surgeon may be asked to anticipate his needs for each individual case scheduled. We must not neglect or endanger the patient, but if everyone conscientiously tried to economize the consumption of materials would be reduced greatly.

Perishable foodstuffs should be purchased with great care and storage facilities should be improved and routinely maintained to reduce spoilage. A per capita portion study should be made and more accurate estimate of foods should be stressed.

Food handlers and servers must be made to realize that they must not serve extravagant portions.

Posters may be used in dining rooms and cafeterias to remind people not to take more than they can eat.

Information on menus may help to educate the patient that hospitals are having difficulty getting supplies and proper personnel to maintain normal high standards of service.

DEPARTMENTAL MEMORANDUM

TO: DATE: May 2, 1942

FROM:

SUBJECT: Committee on Conservation

In accordance with the attempt being made to reduce the amount of linen used weekly in all departments of the hospital, the head nurses were asked to reduce the consumption on their floors and submit the results. At the last nurses' staff meeting the following list of reductions was described by each head nurse for her floor.

Floors	*Approximate Reduction*	*Floors*	*Approximate Reduction*
M-2	1/3	S-1	1/5
M-3	1/3	S-2	1/2
A-1	1/2	S-3	1/2
A-2	1/3	S-4	1/2
A-3	1/4	S-5	1/3
		S-6	1/3

THE CITY HOSPITAL OF AKRON

Merchandise Requisitioned During Average Operating Day

January 1942	$250.34
February 1942	232.47
March 1942	209.68

These figures represent a $40.66 average daily decrease in consumption of materials.

Salvage Report

Statistics showing the results of a salvage and conservation program at the City Hospital of Akron. Patient days over periods reported remained practically the same.

January 1, 1942, to April 30, 1942

Burlap sacks	200 only
Barrels	27 only
Newspapers	8645 pounds
Magazines	542 pounds
Cardboard	8090 pounds
Mixed paper	15,528 pounds
Rags	757 pounds
Rubber	252 pounds
Metal	1750 pounds
Glass	1964 pounds
Bones	3405 pounds
Fats	633 pounds
Total units salvaged	227
Total pounds salvaged	41,837 (20.9 tons)

This information will make the average patient more tolerant.

The routine servicing of all equipment means the conservation of time for breakdowns.

As the salvage and conservation program progresses, an attempt should be made to compile some statistics showing the amount of material salvaged and the reduction in consumption of the more important commodities. These statistics should be made available to the general personnel, since people are more anxious to continue their efforts if they know what they are accomplishing.

No loyal American citizen would willingly defeat any effort toward national defense, yet most of us are unwittingly doing that very thing. We are so accustomed to plenty in all commodities that we have been careless and wasteful of supplies, utilities and possessions. To conserve supplies and to salvage used materials should be considered a privilege. This constitutes a minor sacrifice on our part.

All of us should immediately organize a program of this type since, without an abundance of supplies, our armed forces cannot function; the more material that is made available, the quicker the present conflict will end. We must concede that the war and the prosecution of the war come first, but those of us who are passing through this present experience may well consider this effort an opportunity to gain an excellent appreciation of the efficient use of all commodities and supplies so that the program may continue when peace comes to our nation once more.

Is Concerted Buying the Key to Real Economy?

E. E. SALISBURY
Executive Secretary, Chicago Hospital Council

TODAY we are constantly aware of the effectiveness of collective action in labor, government, military and industrial operation. Recognizing this, about five years ago 15 hospitals requested the Chicago Hospital Council to organize a cooperative and centralized group purchasing service.

This organization hoped to achieve the characteristic benefits of collective purchasing through its counterpart, large volume bargaining leverage. This was to provide standard quality merchandise at substantial savings and some reduction in the cost of purchasing operations over the usual methods by the introduction of systematically organized control and by alleviating to some degree the burden of selection and the time consumed by solicitors.

Only Standard Supplies Handled

It was found necessary to confine the items to those commonly used and of standard quality. Typical of this group are the following items, which represent the greater proportion of the total volume of orders placed through the purchasing service: commercial oxygen, anesthetics, electrical goods, dressings and bandages, x-ray films and supplies, paper goods, soaps and detergents, drugs, adhesive, dextrose and cellulose. This list represents only a few of the items that can be purchased at substantial savings for hospitals by a centralized group purchasing service.

The foremost factor in the success of the project was purchasing standard items at substantial savings to the hospitals. Conversely, to be successful, we discovered that we had to confine our service to those standard items of common use. For instance, in the last six months of 1941, over 90 per cent of the total invoicing was represented by purchases of 16 items. Orders were placed, during an average month, with 71 supply houses. From a dollars and cents' standpoint, only three companies received orders totaling more than $1000 and only five companies received orders exceeding $500.

Approximately 40 per cent of all the items came from four companies with which our department had a written contract or a definite understanding. This discovery enabled us to effect further economy in our operation by eliminating the full-time purchasing agent we had employed. Obviously, his time was consumed by a myriad of small items that were not in common use, whereas our regular organization could successfully supervise the purchase of the standard items.

While the idea was embryonic, the major obstacles to rapid growth and development of service were discovered.

First of all, competition reared its ugly head in several different ways. Some of the hospitals competed with the council. In other words, after we had succeeded in obtaining a substantial discount from one of the firms distributing or manufacturing a standard item, we found that some of our members used our price as a lever for obtaining a similar discount on their own individual purchases.

Competition Caused Problems

Competition existed among some of the hospitals themselves. Also, there was the competition of the dealer located in the vicinity of the hospital who distributed one or more of the standard items. He commanded a natural fealty on the part of the hospital, which would favor him whenever possible. Competition in these disguises was not only difficult to identify but was more difficult to arrest.

The personal equation exists in any form of business enterprise. An example of this lies in the merchandising of food by small independent retailers. Each preferred to run his own business without the aid and cooperation of others; only when the pressure of the large chains became intense and severe did the small grocers band together under such organizations as the "Rite-Way," "Shield of Quality" and "Blue Front," designed exclusively for the purpose of obtaining for the independent operator, through collective purchasing, the benefits and advantages of the large chain competitor so that he could continue to survive as a business enterprise. Despite the fact that public sympathy was with the small retailer *versus* the chain store, still the public spent its money on the counter of price and service. We should take heed.

Hospitals Have Moral Obligation

This is in no way a criticism but simply an observation of an extremely unhealthy condition that is all too prevalent in the hospital field in general. As long as hospitals continue to receive the privileges and exemptions that are theirs today as a result of their charitable, community-serving, not-for-profit organization and operation, they are morally bound to exercise every reasonable and justifiable means at their disposal to operate as economically and efficiently as possible. Abuse of privileges eventually results in either denial or restriction.

It requires untiring effort to achieve necessary cooperation. If the larger institutions will cooperate and combine their purchases on items of common use and standard quality,

(*Continued on page* 48)

From a paper presented at the Tri-State Hospital Assembly, May 8, 1941.

Collective Action Is Unity, Says Mr. Salisbury, *but* Mr. Scheidt Prefers Individualism

ALBERT H. SCHEIDT
Administrator, Miami Valley Hospital, Dayton, Ohio

A GOOD purchasing agent is a person who has the ability to buy the right supplies in the right quantities at the right price and at the right time.

To be able to do this, his qualifications must include honesty, ingenuity, fairness, frankness, pleasing personality, loyalty, broadmindedness and common sense. A sufficient amount of time must be allotted him to use these characteristics to the utmost. He must be familiar with market conditions and tendencies in order to know from where to get products, when to get them and the right price to pay for them. He must have a general technical knowledge of the various supplies used in the institution.

Saves More Than His Salary

A person possessed of these qualities to a degree sufficient to be a good purchasing agent cannot be hired cheaply. Likewise, the purpose of a purchasing department is not one of saving on the salary of the purchasing agent but rather one of obtaining the type of purchasing agent who can save the hospital money many times over the cost of his own salary.

Hospital administrators, by and large, if they are successful, possess the same characteristics and qualities. However, they do not have a sufficient amount of time to use them to the best advantage of the institution. Those who use an amount of time necessary for purchasing will find in many instances that they are doing so only by sacrificing time that rightfully belongs to the hospital as a total entity rather than to a specialized department.

From a paper presented at the Tri-State Assembly, May 7, 1941.

When we consider that 65 cents out of every dollar is spent for personnel and that personnel expenditure is another form of money in our institutions, how narrow-minded is the superintendent who feels that, having done a good job of buying alone, he has displayed a proper administration of his institution. Personnel dollars are even more fickle than supply dollars, for once the minute has passed the personnel dollar is either returned to the hospital in form of service rendered or is lost to the hospital in terms of service wasted.

Administering the remaining 35 cents out of every hospital dollar is the business of the purchasing agent.

The relation of the purchasing agent to the administration is that of a major department head. In such a capacity, his functions are many. He must do his own buying, since he best, through cooperative effort with other department heads, can determine what should be the product used in the particular institution.

Avoids Purchasing Bureaus

He should avoid the use of buying or purchasing bureaus. Such usage of a centralized bureau is an admission on his part of a lack of knowledge of good purchasing essentials. It is evidence that he does not appreciate the fact that such bureaus represent a cancerous type of infection in the hospital field. So long as the general condition of the patient is good the infection can be tolerated, but let the infection become too great or spread over too great an area and the patient loses not only his health but his life as well.

The efficient purchasing agent recognizes that the hospital field has good sources of supply that carry stock, that carry accounts receivable, that employ salesmen, that employ technical specialists, that support research departments and that provide, create and make scores of items. He recognizes, also, that in the long run petty savings arising from centralized purchasing from questionable sources may lead to a breakdown of these better companies.

If such bureaus were economically sound, collectively they would have thousands of members buying through them instead of the few paltry hundreds that have found their services desirable.

Individual Buying Is Practical

The purchasing agent knows that buying bureaus, by their own admission, would lose money in trying to cover purchases of miscellaneous items that they are not capable of handling properly or of servicing intelligently. Further, proper support by the financial department and a proper volume, based on usage, permit the individual buyer to do better in prices than could be done by an organization that includes in its group members who pay their bills slowly, who buy in dribbles and, finally, who evade their responsibilities to their board by assigning their purchasing to an individual not under the administrative control of the individual hospital.

The purchasing agent should be better fitted to purchase for a particular institution than is a buying bureau, which is in no position to judge what is good for that hospital or what quality and character exist in some article from a company that does not risk its reputation and capital by guaranteeing its merchandise to be adequate, desirable and proper.

Recognizing salesmen as helpful ambassadors to the hospital is a healthful attitude for the purchasing agent to assume. These men are representatives of first line companies the future of which lies entirely in the furnishing of a type of product that will assure their perpetuation.

Buying bureaus consider these salesmen as expensive luxuries; in forming such a misconception, they have not missed the point any more than they have in their other thinking.

While the visits of individual salesmen cost pennies in terms of time consumed, they have earned for the hospital dollars in terms of suggestions made. First line companies are constantly bringing new things into the hospital field. Common sense dictates that new products have to be developed before they can be purchased and that this developmental cost must be borne in the price of the products sold by the first line companies until the developmental cost has been recovered.

Duplication of the product by shyster organizations, which deal on price alone, does not necessarily mean that such shyster companies should be encouraged by purchasing through bureaus whose exclusive claim for furtherance exists in the price savings they are supposed to effect. Scabs and scalpers have no more place in hospitals than they have in industry. Temporary cheapness is long-time loss.

The purchasing agent must stand on his own feet and not lean on a crutch. His internal relation to the administration and to the rest of the departments should be one that recognizes the purchasing agent as an important individual in the administration of the hospital. If he is to buy intelligently, he must have the channel made clear for him to follow the product purchased all the way through the organization.

Several years ago many hospitals were shown how they could save hundreds of dollars by buying syringes "just as good." In the institutions in which breakage was closely correlated with the purchasing procedure, it soon became evident that what seemed to be a saving on a unit cost basis was, in reality, a loss in the aggregate cost owing to increased breakage arising from an inferior product. Superimposed on this short-sighted policy was the additional ill will created by the introduction of such an inferior product. In a few cases on record, patients' deaths were attributable to it.

The function of the purchasing agent includes the control of the storeroom and the quantity records, as well as price records, so that he assists in placing future orders by the hospital's total experience in the past rather than on price alone.

The purchasing agent realizes that trick deals resulting in a lower unit cost are only desirable transactions when the product is one generally acceptable within the institution. Further, he must review periodically the consumption of a number of items and study the comparative usage routinely so that an educational program may be carried on within the institution leading toward elimination of excessive waste. By comparison of price *versus* volume used, by control of stores and by study of consumption, the good purchasing agent should be able to work well with other department heads in the institution.

There has been an antiquated attitude among hospital administrators toward recognition of the purchasing agent as the final authority on what is purchased. Two catch phrases annually cost hospitals hundreds of thousands of dollars each year. The first is: "In the hospital, it's different." The second, which enjoys an equal reputation, is: "We have always done it the other way."

Lest anyone gather the impression that the purchasing agent should be empowered to purchase what he pleases, let such a person be assured that industry does not tolerate a situation of the sort. Neither should hospitals tolerate it.

The purchasing agent, being responsible for the financial aspects of a situation, must, in the last analysis, close the deal. He is not a superauthority on the relative value of all items used in the hospital any more than is the purchasing staff in an automobile factory responsible for designing motor cars. However, the purchasing agent is entitled to receive from each department head specifications as to what the department head wishes; having been given these specifications, the purchasing agent can then draw upon his purchasing ability to supply the department in the most economical fashion.

Department heads who say that because of the technical nature of their supplies it is impossible for a purchasing agent to purchase intelligently what they need are indicating their own inability to set up intelligent specifications for their departments.

The relation of the purchasing agent to the administration is of a diversified nature. If he does the job properly, it includes a study of the shelf life of supplies and a recognition of the association of seasons with buying and of cost differences resulting from the variation in packaging of certain items. By his attendance at meetings, by his close association with salesmen, by his suggested ideas with respect to new products, by his concentration on new products, he will be able to do a difficult task in a creditable manner.

Collective Action Is Unity

(*Continued from page* 46)

the smaller and less fortunately situated hospitals in the community can effect a similar savings. If this will enable them to provide more extensive services with the limited funds available, there is no justification for their refusal to cooperate.

The hospital council has a challenge to demonstrate to the hospitals, both in practice and education, the effectiveness of centralized purchasing, and the hospitals are challenged to lend their complete cooperation and support until such time as collective purchasing has been proved useful or useless.

From my own experience, which I grant is limited, I can say that there is no other field in which there obtains as much discrepancy in prices of necessary commodities as will be found in our own hospital operations. This situation is largely a result of our own independence of action. This condition has flourished in the past only by the permission of the hospitals themselves!

We are optimistic about the future possibilities of this phase of hospital operation and propose to work religiously for its adoption and enthusiastic acceptance by all. In our hospital council, we believe that maximum usefulness to the hospitals will produce maximum benefits and assure maximum survival for us.

Allocating Doctors in War Time

CLAUDE W. MUNGER, M.D.

Director, St. Luke's Hospital, New York City, and Chairman, Council on Government Relations, American Hospital Association

AS SOON as the national Selective Service Act was passed, it became evident that the act, alone, would be inadequate for providing a military force augmented with physicians without serious, indeed, dangerous, depletions of the medical personnel needed for the civilian population.

The Selective Service Act took great care to avoid any provisions that could be construed as giving preferment to or penalizing any profession, any trade or any special class. Its only exception was in the case of the clergy.

As a result of the Selective Service Act's failure to give special attention to the medical situation, there was early agitation for amendments to satisfy the country's medical needs as a whole and to protect the health interests of soldiers and civilians alike. Naturally, amendments to satisfy medical needs, if considered, would bring a deluge of similar requests from other professional and technical groups. Finally, the health and medical committee, an important official advisory group to the federal government, recommended that a trial be given to a plan whereby every physician in the country would be "questionnaired" and then listed in a master, national file designed to contain all pertinent facts with regard to each man and to represent a documentation of the entire profession of the country.

It was also proposed to work out a plan whereby this medical manpower could be mustered and equitably distributed between military and civilian needs and whereby physicians serving the civilian population could be redistributed insofar as that might be found necessary in looking after areas or districts found to be seriously short of medical coverage.

Paper presented at Southeastern Hospital Conference, Memphis, Tenn., April 11, 1942.

The key position of civilian hospitals in this scheme was early recognized as it became evident that physicians left for civilian service would need to work efficiently in order to encompass the civilian medical needs. It was also evident that for a long war, there would need to be a steady and augmented production of physician replacements and that the hospitals were absolutely essential to the completion of that portion of medical education offered by medical schools.

The need of some such special handling of problems of medical personnel was recognized by the President and his advisers. As a result, a new bureau was created, the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. This new activity was assigned to function as a division of the Federal Security Agency and is under the general supervision of Federal Security Administrator Paul V. McNutt.

Hospitals shoulder a grave responsibility in the scheme of procurement and assignment. Administrators must conscientiously assist their staffs in devising ways and means of giving good hospital care to the civilian sick without wasting the professional talent needed for the war effort

Upon recommendation of this board, Mr. McNutt then appointed various committees to act in an advisory capacity to it. Lieut. Col. Sam. F. Seeley, Medical Corps, U. S. Army, was chosen as executive officer of procurement and assignment.

The directing board and Colonel Seeley have approached their task in a most energetic manner and, with the aid of organized professional groups and of the special advisory committees, have made an excellent start. Their task is a gigantic one, but it is my belief that the effectiveness of procurement and assignment will be increasingly felt and that the basic plan, a sound and logical one, is capable in time of full and orderly realization. It deserves the cooperation and positive support of all of us because it is our surest safeguard against chaos in matters of medical personnel.

The opinion is expressed that, despite our impatience, the service is moving forward as fast as is feasible when one considers the recency of its establishment, the immensity of its task, the practical difficulties, so well illustrated by delays in government printing of the needed forms, as well as the necessity for the professions and agencies concerned to be educated to the service's functions.

The advice of the committee on hospitals has been freely asked and as freely given. The members of the committee have been pleased that their considered suggestions relative to hospital phases of the work have been adopted.

In the pre-Pearl Harbor period, when hospitals were mainly concerned over losses of interns and residents, a plan was evolved whereby a committee of three would be set up in each Army corps area to advise the corps area surgeon in relation to inductions into service of members of hospital house staffs and other recent medical graduates. A representative of hospital administration was included on each of these corps area committees.

When war was declared, it became clear that we would have a much larger Army needing many more medical officers and that hospitals would be as much concerned over possible losses from their attending

staffs as they had formerly been about their interns and residents.

Accordingly, when it became evident that procurement and assignment would have to have constituent committees in the corps areas and in their subdivisions, the personnel of the advisory committees to corps area surgeons was transferred to the corps area committees of procurement and assignment, which were given much broader duties than had been intended for the original committees.

Each new committee consists of eight rather than three members; one of each of these groups of eight is a hospital administrator. They are: first corps area, Dr. Nathaniel Faxon; second corps area, Dr. C. W. Munger; third corps area, Dr. Winfred Smith; fourth corps area, Dr. J. Moss Beeler; fifth corps area, Dr. Robert H. Bishop; sixth corps area, Joseph G. Norby.

Under each corps area committee, there are, for each state in the area, state chairmen for medicine, dentistry and veterinary medicine. Reporting to each of these state chairmen is a committee representing the appropriate county professional society or group. In large urban centers the county committees are very important.

Hospital Representation Needed

I think it is regrettable that in these larger centers there is not some definite and official manner in which the hospitals may be represented because, however well intentioned, committees representing county medical societies will often lack understanding of hospital problems. It is natural, perhaps, that the thinking in medical society groups centers upon the problems of the average practitioner and is not necessarily directed toward the needs of the community for hospitalization or toward the staff problems of hospitals. It would safeguard the success of procurement and assignment if it had sound hospital advice in the larger counties.

Procurement and assignment has already mailed to the hospitals of the country blanks that enabled each institution to list its entire staff above the grade of first year intern and to designate which staff members are considered available for military service (or displacement to other locations) and which men are considered as necessary to the operation of the hospital and who, thus, must be listed as not available in the hospital's report.

While procurement and assignment leaves it to the individual hospital to decide by its own methods which of its doctors and dentists are available and which are not available, in few instances should the administrator take the full responsibility for decisions so important to the individual members of the staffs. An orderly manner for arriving at these decisions would include discussion of the problem by the executive group of the medical staff with formulation of a method whereby the particular hospital will decide upon the availability of its men for government service.

Few Exceptions Expected

The director of procurement and assignment has indicated that every physician who has had his internship and who is under 45 years of age should be designated as available unless the hospital has and can substantiate valid reasons why the man cannot be spared. Procurement and assignment advises hospitals against attempts to retain physically fit physicians, under 45, and fully expects that hospitals will not try to retain such men unless and until they have exhausted the possibilities of staffing themselves with doctors over 45 or those under 45 physically disqualified for military service.

The immediate program of the armed forces contemplates the induction, before January 1, 1943, of 16,000 medical officers. This figure includes the demands of all branches of the service. In this total are the heavy demands of our expanding air force which, according to Colonel Seeley, needed 2500 physicians by July 1, 1942, and will require 600 additional physicians each month up to the end of the year.

According to quoted estimates there are in the nation 80,000 physicians of eligible age. The induction of 16,000 men will mean that 20 per cent of our young and active men will leave us by the end of the current year.

On the other hand, hospitals may, in fairness, question whether hospital staff members can or should be spared in as high proportion as these figures suggest—especially those hospitals whose normal staffs are no more than sufficient for the demands of the community.

The patriotism of the doctors themselves and that of the hospital authorities will result, no doubt, in the willing release of a maximum number of physicians. However, the hospital that, in its questionnaire, gives evidence of unwillingness to "give until it hurts" will be recognized and cannot expect to have unreasonable requests sustained by its corps area committee, which will have power to review all disputed cases.

As soon as the hospital's reply to the questionnaire has been submitted, no man designated as not available will be cleared by procurement and assignment for a commission or other federal appointment, even if the man himself has applied for such, without special review of the individual case. The hospital must be prepared to defend its requests to retain physically fit men under 45 years of age.

Discourage Older Applicants

According to Colonel Seeley, applications for commissions by physicians over 45 are not expected or particularly desired. It is the hope of procurement and assignment that these older men will remain where they are and thus release physicians within the draft age for induction.

Hospital administrators are advised to deal with their local committees and not directly with Washington in relation to the problems concerning procurement and assignment that will inevitably arise.

Practically all hospitals are deeply concerned over the maintenance of at least a minimum standard of house staff service. Hospitals with approved internships will probably be permitted to retain interns for a total of twelve months' training following their graduation. A certain number of men may be retained in approved residencies and fellowships, after the intern year, and where such men are receiving high grade instruction and are badly needed by the hospital it is justifiable to request their retention by the hospital for a reasonable period. Some of the house staff needs can be covered by women physicians and a still greater number by young, but physically disqualified, male physicians. That hospitals will, in the end, have to get along with fewer residents is quite evident.

War-Time Standards Are Different

ROGER W. DeBUSK, M.D.
Administrator, Evanston Hospital, Evanston, Ill.

IT HAS long been expected by private patients that they be given treatment as though they were all acutely ill. The wealthy patient who is in for his semiyearly checkup often complains if he is not given his bed bath and his back rub on the dot, even though he is not ill and does not expect or receive these things at home.

There is the doctor who complains that the nurses are not standing beside him while he goes in to see his convalescent patient and exchanges pleasantries with him. His vanity screams "poor service" at the administrator, even though there is no dressing to do, no chaperoning necessary and when all the pertinent information is on the chart. I wonder what this has to do with the standard of care?

There is the nurse who feels that certain procedures are beneath her dignity and must wait for the engineer to arrive to replace the burned out bulb or for the maid to wipe up a half cup of spilled water even though she could save ten minutes by doing it herself.

There is the intern who sulks because he must see the patient who has just expired when he is not on that service any more, even though he is to be on the floor for the next half hour with nothing in particular to do.

How do the foregoing procedures fit in with a real approximation of standards?

The field of physicians' orders is one that has a vital bearing on the problem of maintenance of standards. It is not the province of the administrator to determine what is necessary and what is not but he may and should raise the issue to the point of creating interest in the minds of the staff members and asking their suggestions on what may or may not be eliminated without derogatory effect on patient care. We all see daily many orders that have no effect except for didactic interest and possibly for their value in the physician's ritual of care. This necessarily makes mandatory a tight control of the pharmacy through its personnel and through the formulary.

The dietary department must be given the right to ask the reasons for certain special diets. Often the raising of an eyebrow with the attendant "Why?" is sufficient to save many hours of labor and many supplies without the slightest effect on patient care. At the same time, certain substitutions, especially in the field of pharmacy and dietary, may become necessary and will not affect standards. Others, of course, which lower standards and which are the most flagrant examples of false economy and interference with what is best for the patient must not be tolerated.

In times such as these there is little, if any, place for the niceties that have no actual bearing on the problem of rehabilitating the sick in the shortest possible period of time

Much has been written about the delegation of duties to workers who previously have not been thought capable of assuming a more important rôle. If we, as hospital administrators, have not attempted to keep the intelligence level of our personnel up to a good average we should first remedy this situation. Then we may see how far we can assign duties without affecting standards of service.

The whole problem is one of education and supervision. Attendants and ward aides can enlarge their scope if they are adequately controlled and have a clear-cut definition of professional and nonprofessional duties. This is necessary not only from the standpoint of standards but from the legal standpoint as well. Many procedures and duties formerly carried out by lay employed personnel can be taken over by volunteer aides without disturbing standards in any way, provided one bears in mind the concepts of professional practice, confidential communications and adequate supervision. I have reference to telephone answering, guide work, care of flowers, making of supplies and various kinds of secretarial and clerical work.

The problem of research presents many difficulties. None of us would tolerate curtailment of honest research. Nevertheless, it seems wise to set up the machinery in our own staffs to decide that which is and that which is not worth while. Research that is expensive and is of questionable value drains material and time from hospital duties which, if we accept time and supplies as constants, might reflect in the lowering of standards.

In Evanston Hospital, where we have the facilites for a large amount of research, we have recently established a committee to control these projects with the result that the four projects now in progress are important, clinical rather than didactic, and admittedly not wasteful. We do not feel that we have lowered our standards of service by control of research. In fact, from the long range point of view, we may have increased standards while saving materials.

In normal times we strive constantly to raise standards; we should make the same effort in abnormal times. Certainly, with attention to principle and to detail we should not need to countenance any slipping of the standard of patient care.

Adapted from a paper presented at the A.C.S. War Session, March 9, 1942.

Contagion Succumbs

H. P. VanARSDALL
Samuel Hannaford & Sons, Consulting Architects, Cincinnati

THE design for a communicable disease hospital is quite different from that ordinarily used for a general hospital because all avenues for contaminated travel, so far as is possible, must be direct from entry to destination without crossing uncontaminated paths; patients must be isolated individually and by disease, and physical provision must be made throughout for practicing such aseptic technic as will safeguard patients, doctors, hospital personnel and visitors. All of these principles have been observed rigidly in Pittsburgh's newest hospital.

Because of seasonal differences in incidence of the numerous diseases, patient floors are planned with considerable flexibility to take care of variations in the census of any one of several diseases. By referring to the plans it will be found that each floor is divided into two distinct major nursing units, each of which is subdivided into eight minor units.

The patient, on entering the hospital, is received in the basement admitting and detention section, divested of all personal effects, bathed and examined; he is then temporarily hospitalized until the degree and type of illness are determined. His clothes are sterilized for four hours in a closet (dry) heated to a temperature of from 125° to 140° F., after which they are placed in a sealed envelope and hung in a clean storage room, awaiting his release from the hospital. Valuables, such as jewelry and coins, are washed in alcohol, sunned and aired for six or more hours, after which they are stored in the office vault.

When the type of disease is determined, the patient is taken in a wheel chair (protected by a sheet) direct to the room or ward assigned him.

In semiprivate rooms and four bed wards, patients' beds are separated by 7 foot high glazed metal cubicle partitions, constructed so as to prevent child patients from passing contaminated toys and articles from one to another. The upper sections of partitions are glazed to provide visual control, and "safety glass" has been used to eliminate the breakage hazard. Each cubicle is equipped with reading lamp, night lamp for observing the patient while he sleeps, nurses' call and a duplex electric plug for examination lamp. All private and semiprivate rooms and wards have adjacent private toilets.

Ward technic for prevention of cross infection is accomplished by providing in each cubicle individual gowns (hung on wall hooks) for use of the doctor and nurse while attending the patient. On leaving a patient, the doctor and nurse remove their gowns, wash their hands at the pedal-operated lavatory near the door and then proceed in the same manner to examine the patient in the adjoining cubicle.

Every precaution is taken to prevent the patient's spreading contamination to others and receiving secondary infections himself. Utensils used for his care are sterilized in the utility room and then returned and placed in a compartment at his bedside ready for reuse. Contaminated sheets and linens are placed in laundry bags and dropped through the laundry chute to the soiled linen sterilization room where they are sterilized before they are laundered.

Magazines, newspapers and other reading matter are disposed of by incineration. Nursing bottles, medicine glasses and cups are first washed thoroughly in the patient's unit and then taken to the utility room for boiling in the instrument sterilizer.

When meals are finished, trays are removed from patients' rooms to carts stationed at convenient places in corridors, from where they are wheeled to the dishwashing and sterilizing rooms. Liquids are poured into disposal sinks, dry waste is disposed of in the incinerator and dishes, trays and silverware are placed in automatic washers and sterilizers for complete sterilization. On completion of the sterilizing process, the dishes are discharged directly into the clean service kitchens where they are stored.

Patients are permitted to have one visitor for ten minutes only on visiting days. An exception is made, however, in the case of the seriously ill patient, who may have visitors at any time.

The visitor, on arrival at the information desk, removes his outer wraps and hangs them on a clean clothestree in the gown room. A nurse then attires him in a gown and permits him to walk down the corridor to the patient's room, where he may talk through the door opening. Visitors are not allowed in patients' rooms.

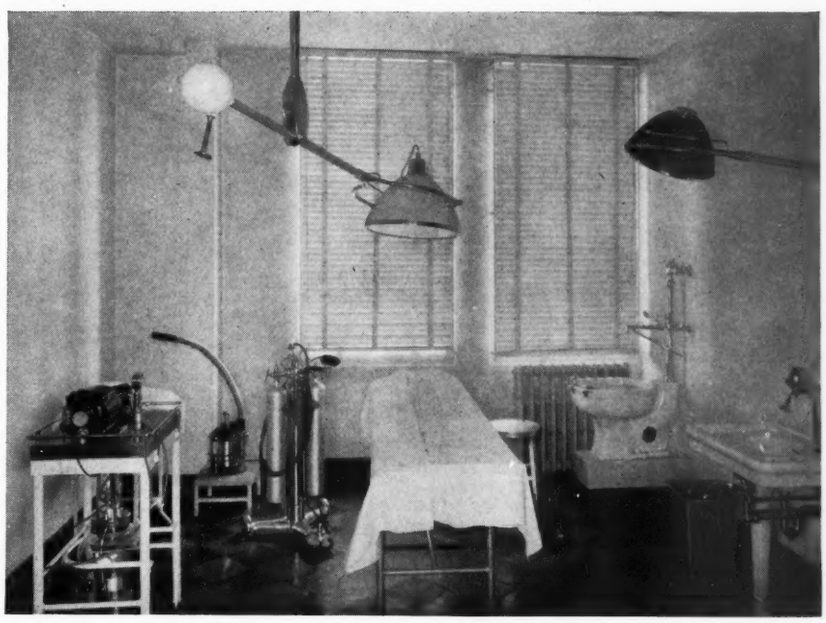
Special facilities are provided for the care of those patients who develop complications that require sur-

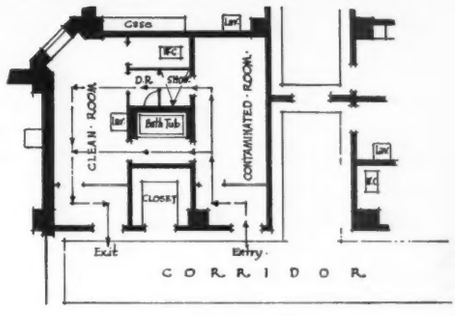
to Science

J. S. BAIRD, M.D.
Municipal Hospital, Pittsburgh

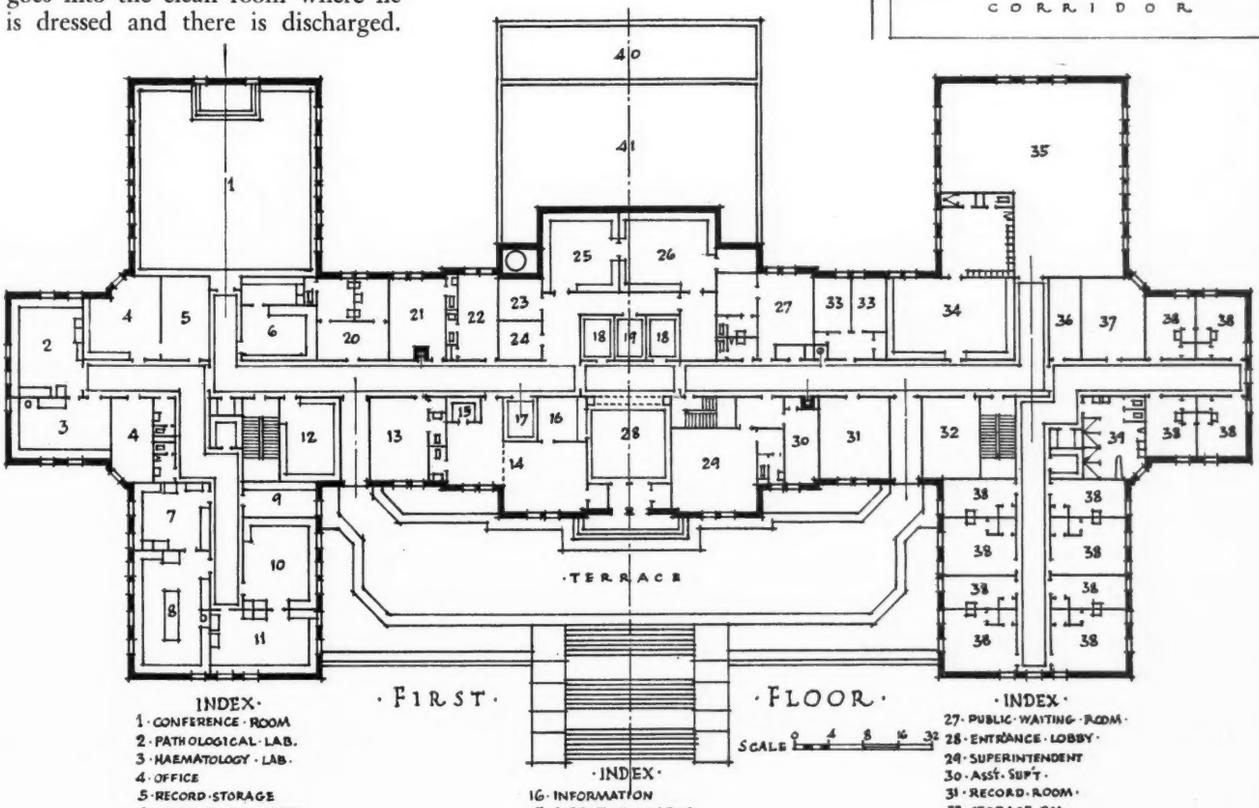
gery, dental treatment, x-ray treatments and superficial therapy.

When the patient ceases to be a carrier of infection, he receives the process of "terminal disinfection," after which he is ready to be discharged through the discharge unit located near the exit in the basement. The unit consists of a contaminated room and a clean room separated by a shower and dressing space, tub space and water closet compartment. The patient first goes to the contaminated room where he removes his hospital garments and deposits them in a soiled clothes hamper; he then passes through the shower bath or, in the case of an infant or infirm person, is bathed by the nurse in the tub compartment, after which he goes into the clean room where he is dressed and there is discharged.





Above: The intubation room is completely equipped with modern facilities. Right: Plan of patient discharge section in the basement. Below: Plan of first floor. Opposite Page: Exterior view of Pittsburgh's new municipal communicable disease hospital.



INDEX·
1·CONFERENCE·ROOM
2·PATHOLOGICAL·LAB.
3·HAEMATOLOGY·LAB.
4·OFFICE
5·RECORD·STORAGE
6·MICRO-PHOTOGRAPHY·
7·KITCHEN·
8·CHEMISTRY&URINALYSIS
9·CLASS ROOM
10·SEROLOGY
11·BACTERIOLOGY
12·LAB·STORAGE
13·SUP'T·OF·NURSES
14·GENERAL OFFICE
15·VAULT

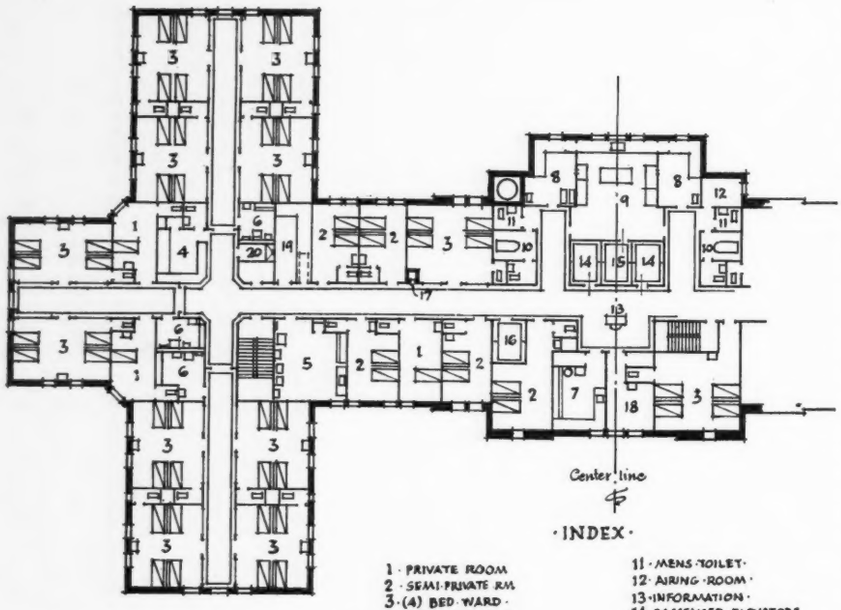
·FIRST·

·FLOOR·

SCALE 0 4 8 16 32

·INDEX·
16·INFORMATION
17·PATIENTS ELEVATOR
18·PASSENGER·ELEVATORS·
19·SERVICE ELEVATOR
20·GENITO·URINARY·
21·INTERNES·LOUNGE
22·HOUSEKEEPERS·OFFICE
23·UNCRATING·ROOM
24·OFFICE
25·MIXING·ROOM
26·DRUG MANUFACTURING

·INDEX·
27·PUBLIC·WAITING·ROOM·
28·ENTRANCE·LOBBY·
29·SUPERINTENDENT
30·ASST·SUP'T·
31·RECORD·ROOM·
32·STORAGE·RM·
33·PHYSICIANS·
34·DOCTORS·LOUNGE&LOCKERS·
35·STORAGE·SPACE·
36·TRUNK·STORAGE
37·MALE·HELP·LOUNGE·
38·BED·ROOMS
39·MENS·TOILET·
40·COAL BUNKER
41·UPPER PART OF BOILER RM·



·THIRD & FOURTH
TYPICAL·FLOOR·PLAN

SCALE· 0 8 16 24 32

·INDEX·

1 · PRIVATE ROOM
2 · SEMI-PRIVATE RM.
3 · (4) BED WARD ·
4 · NURSES STATION ·
5 · UTILITY ROOM ·
6 · SUB-UTILITY ROOMS
7 · LABORATORY ·
8 · STERILIZING & DISHWASHING ·
9 · SERVICE KITCHEN
10 · WOMENS BATH & TOILET
11 · MENS TOILET ·
12 · AIRING ROOM ·
13 · INFORMATION ·
14 · PASSENGER ELEVATORS
15 · SERVICE ELEVATOR
16 · PATIENTS ELEVATOR
17 · INCINERATOR ·
18 · VISITORS GOWN ROOM ·
19 · LINENS & STRETCHER ·
20 · JANITORS ROOM ·

Construction Details

GENERAL DATA: Building is skeleton type of reenforced concrete with enclosing walls of brick and interior partitions of hollow tile. Faces of exterior walls are smooth face buff brick with spandrel panels. The building is 12 stories high and measures 293 feet across the front at the foundation line. Makes available 221 beds for cases of whooping cough, measles, diphtheria, scarlet fever and erysipelas.

WINDOWS: Exterior windows are of steel, casement type, with metal insect screens over ventilating sections.

DOORS: Door frames are of the flush metal type. Doors are of enameled hollow metal, flush type, and are equipped with hardware suitable for a communicable disease hospital.

FLOORING AND WALLS: Marble wall facings and floors are used in the main entrance vestibule and lobby. All partitions forming shower and water closet compartments in toilet rooms are of polished marble. Wainscots in operating rooms and sterilizing rooms are of pale green structural glass. Elsewhere, wainscots are of matt-glazed cushion edged tile in selected colors.

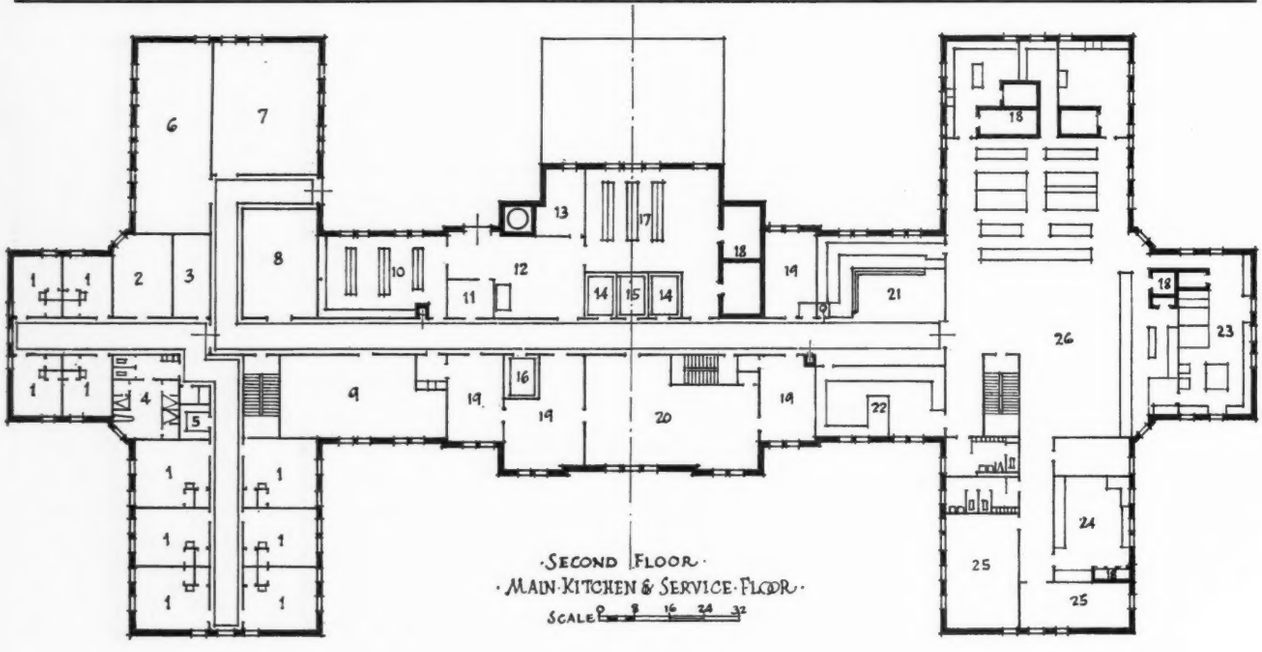
HEATING AND VENTILATION: Low pressure steam type with automatic temperature regulation in selected areas. Kitchen, utility rooms, toilet rooms, laboratories have an exhaust system of ventilation. All operating rooms are equipped with a conditioned air supply and exhaust system.

LIGHTING: Electric wiring system includes power for all motors and x-ray units, lighting, emergency lighting, signals, clocks, telephones and fire alarm.

ELEVATORS: Automatic self-leveling electrically operated push button type.

MISCELLANEOUS: Cases, cabinets, shelving, blanket and warming closets are of metal, except in the laboratory where wood is used.

COSTS: Total building cost, $2,117,386.45; cost per cubic foot, complete with equipment and including architects' fee, 93.1 cents; cost per patient's bed, $9581.



·SECOND FLOOR·
·MAIN KITCHEN & SERVICE FLOOR·

SCALE 0 8 16 24 32

·INDEX·

1 · FEMALE HELP DORMITORY ·
2 · " " LOUNGE ·
3 · TRUNK STORAGE ·
4 · TOILET & SHOWER RM
5 · LINEN CLOSET ·
6 · MACHINE & PIPE SHOP ·
7 · PAINT & CARPENTER SHOP ·
8 · FURNITURE STORAGE ·
9 · MEDICAL SUPPLIES ·
10 · SURPLUS FOOD SUPPLIES ·
11 · RECEIVING CLERK ·
12 · UNCRATING & RECEIVING RM.
13 · TUBERS ·

·INDEX·

14 · PASSENGER ELEVATORS
15 · SERVICE ELEVATOR ·
16 · PATIENTS ELEVATOR ·
17 · GENERAL FOOD STORAGE
18 · REFRIGERATORS ·
19 · PRIVATE DINING ROOMS ·
20 · NURSES DINING ROOM ·
21 · CAFETERIA ·
22 · DISHWASHING
23 · BAKERY
24 · DIET KITCHEN ·
25 · HELP DINING ROOMS
26 · MAIN KITCHEN ·

"My Husband Had an Operation"

MRS. TALBOT F. HAMLIN
New York City

JOHN had been putting it off for two years until an important case was out of the way or his partner was back from Washington or something else could be cleared up. At last, in the early summer, our family doctor said he wouldn't like to be responsible for the risk of longer delay, so we took a deep breath and made arrangements. It was our first hospital experience.

In the semiprivate room we found a young man kicking up his heels on one of the beds, in the best of spirits because he was leaving next day—his case had been similar to John's. He was an attractive chap, a premedical student who had switched to psychiatry and then to radio script writing.

"Oh, they'll keep you busy tonight. First, the orderly will push you around, then, the nurses. You'll get a meal all right but they won't let you keep it." The fellow was merry about it and looked back on his two weeks here as such a good joke on himself.

John felt so foolish tucked up in bed while perfectly well that he got permission to sit in a chair. He was going to have a general anesthetic; Mr. Dubinoff had had a spinal. "I was watching everything that went on," he said.

He went on to give us an entertaining picture of personalities and prejudices—the strange patients who had shared this room with him for short periods, the feuds between the floor nurse and the orderlies, how the regular nurses sniff at the private nurses in caps, how uncomfortable the hospital night robes became after the first few days (John liked their open backs and didn't go into his own silk pajamas till the very end of his stay).

I left for dinner and when I came back John was getting drowsy from his sleeping pill. Our young companion adopted me then and I was given a full course of advice for myself. "Don't be in the room when they bring him down tomorrow. They'll toss him from the stretcher to the bed like so much driftwood—of course it won't do him any harm and he won't know anything about it, but you won't like it. I saw them bring down this other guy and I know."

Next morning when I got to the hospital, John was already in a heavy daze from a preliminary hypodermic. We had decided on having special nurses for the first day and Mrs. Greer was already in attendance, a lovely person with gray hair who seemed to combine graciousness with efficiency. She suggested I go up to the solarium, where I could see our patient being wheeled out after the operation. I thought I'd go to the corner florist first for some flowers. "Better wait till tomorrow," she said. "He won't notice them today and you'll save a day in freshness if you get them in the morning."

Have a look at your own institution through the eyes of a perceptive woman who packed her sense of humor along with her husband's silk pajamas when, together, they faced the ordeal of their first hospital experience

It seemed, up there in the sunroom, to be taking an uncommonly long time for this "simplest" of all abdominal operations, but finally Doctor Young came down the hall, walking briskly. He stopped when he saw me and sketched quickly how complicated the whole thing had been. The hernia was a bad one. "Like trying to mend a pair of trousers all full of holes," he said.

But now, instead of feeling a great sense of relief, I was more distressed than ever. What if we hadn't acted when we did? Why had I let him do all this extra night teaching at the law school the last three years? Should I have subscribed for the symphony concerts when he really had been too tired to enjoy them?

At the elevator I met the house surgeon—a charming, keen, informal young Adonis. Yes, he said, it had been a difficult operation but Doctor Young had done an amazing job and the patient came through just fine.

Back in Room 323 I found an air of expectancy; there was John breathing heavily, Mrs. Greer taking his pulse and Mr. Dubinoff sitting on the edge of his bed. My mind was still being assailed by all these doubts and Dubinoff said, "I wish you'd sit down."

One of the nurses' aides came in with a vase of flowers—pink carnations of all things! John loathed them, their close stubby fringe, the spicy fragrance of cloves and, above all, this garish color.

Suddenly he drew in his breath and gave a startled look around the room. Afterwards he told us he had been dreaming about all those preparations and just as he opened his eyes he thought, "What a shame. After all this, they haven't even done the operation yet!" But our smiles reassured him and he slept intermittently for another hour.

Dubinoff had just left the hospital when I got back in the afternoon and the nurses were sighing in mock relief.

When the second of our trio of private nurses came on duty in the middle of the afternoon and took charge with a firm hand, she looked as though she had just bitten into something very hard and very sour. She pulled up the shades, asked John how he was feeling and did he want something to drink. He thought some orange juice would be very nice, thank you. "Not orange, but I can give you lemon," she answered, without a smile and in a thin but

not unpleasant voice. She was such a skilled technician and so devoted as well as dogged in her duty that once John had succeeded in making her smile they got on famously. He still insists that she was responsible for his freedom from nausea, through giving him no orange juice, although we learned it's hospital practice in abdominal cases; the anesthetist deserves some of the credit, too.

It was tea and lemon, and lemon and tea and bouillon that first afternoon, along with Miss Maitland's expert care and attention. Contrary to the general opinion, a patient values definiteness in a nurse and a swift sure touch in handling the routine of the job above all the more obvious feminine graces.

There Are Exceptions to Rules

I had my own little lesson from the admirable Miss Maitland. John and I had visited in this hospital before so we knew that when the lights were lowered at nine o'clock the visitors were expected to leave within five or ten minutes. That night, however, John had asked for his nose spray and I had gone home to get it in a heavy rain storm, returning to the hospital just a few minutes before closing time. Dip went the signal lights and a moment later our zealous nurse stepped in, gave me a disapproving look (which, in view of my errand, I hardly felt I deserved), and before I could make my exit she had sent in the floor supervisor who made a stiff little speech about the rules.

John wanted someone with him pretty constantly. They woke him at the crack of dawn. First his temperature was taken before it was daylight and just as he was dozing off again he would be summoned to have his morning wash and toothbrushing; then an interminable wait for breakfast at 7:30, and around 9 a complete bath and changing of the sheets. Nothing then but to wait for visitors and if I was a trifle late he would call up to see what had happened.

The night nurse was a lovely girl, quiet and assured, with a gentle voice. She even brought a touch of poetry into the hospital routine.

Hospitals are great levelers and educators if you give them a chance. Under the hospitalization plan you are placed in a semiprivate room with a succession of other patients from almost any walk of life. John was alone a few days after the operation and I was free to read aloud to him until the next patient was brought in, a frightened young Italian mechanic who had slipped, with a heavy battery in his hands, and received some pretty severe abdominal bruises. He was a big handsome fellow, intelligent but rather shy, and extremely incensed that doctors should poke and maul one's tender insides so regardlessly. He worked for a big restaurant chain and after a day or two was moved into the company's regular ward, where he champed and fumed and insisted he'd be all right if he could only get home to his sister's. They finally put him into a corset and let him go. Looking rather sheepish and immensely relieved, he came in to say good-bye.

This was the week end when many of the regular nurses came down with influenza and for the next few days there were new nurses taking care of the patients every few hours. There was the foreign Miss Jensen, who had the touch of a sledge hammer and a voice to match; there was the ignoramus, who in the emergency hadn't been instructed as to what the various patients required and who didn't have the least imagination about where anything was likely to be or what to do next, and then, bright and early in the morning, in came little energetic Miss O'Connor, who chattered gaily and ungrammatically from the moment she entered, all during the bath and until she beat her cyclonic retreat, a harangue that from anyone else would have been one long grouch but from her was a sort of plea for progress: what all hospitals in general and this one in particular should do about this, that and the other; what "she" ought to say to "her," and you'd think the nurses ought to get the same food as the patients.

The Formal Professional Call

John was feeling much better and we were chuckling over the poor girl's need for this verbal catharsis, when in stepped Miss Westlake, the superintendent of nurses, for her daily call. "Good morning, Mr. So-and-so, how are you this morning?" were the words she used day after day, in the same dulcet cadence, like an elegant and fragile mechanical doll. John said he wondered who wound her up every morning. I know from seeing her in the hall that one of the nurses had to drop the patient's name into her ear just before each stately entrance.

You don't realize how many thoughtful friends you have until you go to the hospital; they bring you fruit and flowers, choice cheeses and wines and books, and best of all, of course, a breezy little whiff of old-time acquaintance (when they don't take their rôle too seriously). And there are the kind of people who write, "Knowing that you must be anxious these days with your husband in the hospital," or, "Among your colorful and various experiences we hardly expected that a hernia would be the next item on the list."

John's most faithful visitor evidently had made a profession of entertaining the sick. She arrived with a flourish on the first morning he was at home to callers. Hardly waiting for the usual exchange of greetings, she seated herself near the bed and with a cultured but challenging "Well!" she launched at once into a carefully studied sequence of Victorian reminiscences.

The Last of the Roommates

The last person to share John's room was also one of Doctor Young's patients—"bravest man you ever saw," the doctor called him, "a wonderful patient." He was a stevedore foreman whose hand had been badly set after a break the year before; to save its usefulness, it had to be opened and some bone removed, the thumb virtually laid aside during this process. This had to be done with merely local anesthesia so that the patient could try his fingers when the work was done to see if they moved.

Both patients were full of admiration for Doctor Young and a little amused at how pleased he was with his own handiwork. "Now, you'll have to admit that is a beautiful cut!" he had exclaimed when John's bandage came off. It was; straight as an arrow, with not the tiniest ruffle. In six months it should be practically invisible. Probably there is something of the prima donna in any extraordinarily good surgeon; certainly there is something of the artist.

How a Small Negro Hospital Helps Control Tuberculosis

A. W. DENT
Superintendent, Flint-Goodridge Hospital of Dillard University, New Orleans

DURING 1938, 282 Negroes in the city of New Orleans died of tuberculosis. On the basis of the American Public Health Association's estimate that for every reported death there are five active cases of tuberculosis in the community, there were 1410 active cases spreading the tubercle bacilli to their neighbors. To serve these cases there are in New Orleans only 140 beds, a little less than five tenths of a bed per annual death.

Of the 42,000 Negro families in New Orleans, some 40,000, or 94.2 per cent, have annual incomes of less than $1000. Behind this fact lie the socio-economic causes of tuberculosis — poor housing, inadequate food and clothing. The problem, then, involves a community in which there is an appalling lack of hospital beds for a population of which at least 94 per cent cannot purchase medical care. New Orleans is, therefore, confronted with the serious public health problem of controlling the spread of infection as well as the provision of increased hospitalization facilities.

With these facts in mind, in 1936 Flint-Goodridge Hospital decided to transfer the treatment of tuberculosis from its general medical clinic and establish a tuberculosis clinic for the treatment of suitable patients, thereby assuming some responsibility for control through providing ambulatory treatment and emphasizing early diagnosis. Flint-Goodridge Hospital cannot and will not try to carry much of the New Orleans tuberculosis burden; the hospital is too small for that. But it can conduct a demonstration or teaching clinic with an active collapse program as an essential portion of it.

The clinic was begun with an appropriation of $300, obtained jointly from the Tuberculosis and Public Health Association of Louisiana, the Tuberculosis Committee of New Orleans and the Julius Rosenwald Fund. Begun as a cooperative project of the hospital and these three organizations, the sponsorship of the clinic has continued on a cooperative basis and lately the state department of health has provided additional support. Dr. Cameron St. C. Guild of the National Tuberculosis Association has given wise counsel from the beginning. Two physicians formed the medical staff of the clinic: Dr. Sydney Jacobs, instructor in clinical medicine, school of medicine, Tulane University, and Dr. Frederick Rhodes, who at that time had just completed a year as resident physician at the Waverly Hills Sanatorium in Kentucky.

Since this clinic was intended to be primarily an educational center, various case finding procedures have been employed; these have been stimulating to the general staff as well as enlightening to the patients. The earliest was a study to determine the incidence of tuberculosis in women preceding and following childbirth. Recently, well baby clinic patients have been tuberculin tested in an effort to find the possible sources of infection. The staff tuberculin tested all N.Y.A. registrants in 1937, x-raying the positive reactors for the cost of the film. Those found to have tuberculosis were inducted into the clinic for treatment.

The tuberculosis committee of New Orleans tuberculin tests about 1700 public school children each year. Flint-Goodridge Hospital makes chest x-ray films for the committee at cost and agrees to take into the clinic for treatment any of these patients who cannot consult a private physician. The Tuberculosis Committee of New Orleans also contributes from $200 to $300 a year to the clinic for free chest x-ray films to indigent patients. This fund is used to cover only the cost of film and is tremendously helpful in the case finding program.

At present chest x-ray pictures of 1100 N.Y.A. youths between the ages of eighteen and twenty-five are being made. Through the cooperation of the Tuberculosis and Public Health Association of Louisiana and the state department of health, a fluoroscope was placed in the admitting room of the out-patient department; fluoroscopic examinations of the chests of all new patients admitted to the clinics are made routinely. Suspicious cases are x-rayed, frequently without charge to the patients. Approximately 6000 persons a year are reached in this phase of the case finding program.

In 1938 an educational program for Negro doctors was begun; it was designed to arouse their interest in looking more closely for tuberculosis

ONE HOSPITAL'S EXPERIENCE PROVES

1. **A small hospital can help to awaken community responsibility for its tuberculous patients.**
2. **Voluntary and official agencies and racial groups can and must work cooperatively in the development of a control program.**
3. **Well-directed enthusiasm is helpful when funds are meager.**
4. **A pneumothorax clinic can be a focal spot for a community tuberculosis program.**
5. **When there are treatment facilities, educational work is more effective.**

Paper presented at annual meeting of the National Tuberculosis Association held in San Antonio, Tex., May 1941.

in the early stages and to acquaint them with the more modern methods of treatment. This course consisted of biweekly lectures and demonstrations and was directed by Dr. John H. Musser, consultant to the department of medicine and professor of medicine at Tulane University's school of medicine. For the most part, teachers from the two local medical schools were used to give the lectures. All Negro doctors within a radius of 150 miles were invited to participate. Tuberculin was supplied those who took advantage of this course of lectures and they were requested to do a tuberculin test on each patient coming to their offices.

Flint-Goodridge Hospital arranged to x-ray the chests of their positive reactors at the hospital without charge, to make subsequent x-ray films for $1, to provide fluoroscopic examinations without charge and to make a consultation service available. This course parallels a similar one in syphilis case finding and professional education.

Flint-Goodridge also conducts a two weeks' postgraduate course for physicians each summer. During the last five years 20 per cent of the Negro doctors in Louisiana, Texas, Arkansas, Mississippi and Alabama have attended at least one course. Registrants have come from 10 states and 57 towns. At each of these courses a good portion of the time is devoted to tuberculosis instruction. During the last four years an outstanding lecturer has been provided for this purpose through the Negro program of the National Tuberculosis Association.

Prior to the Flint-Goodridge program, no opportunity was offered Negro doctors to study tuberculosis in New Orleans and, of course, there was no incentive to study it—tuberculosis was a problem to be handled by somebody else. When Flint-Goodridge began its clinic (incidentally, the first in New Orleans to use pneumothorax treatment for ambulatory patients) and the parallel professional education program, Negro doctors began to think more of the importance of tuberculosis control and accordingly interested themselves in early diagnosis and treatment. Like all other departments of Flint-Goodridge Hospital, the tuberculosis clinic was designed to provide postgraduate clinical experience for Negro doctors. As the available treatment facilities are inadequate to reduce the enormous death rate from tuberculosis and since no concerted effort was being made to enlist the attention of Negro physicians in making earlier diagnoses, it is hoped that this program can serve as a model for future larger projects for the city. Therefore, we are constantly thinking of how we might develop on a small scale a program applicable to the entire city, for in New Orleans we have an excessively high morbidity and mortality rate among whites as well.

It is the opinion of the tuberculosis staff at Flint-Goodridge that the great majority of hospital physicians now suspect tuberculosis much sooner than they did formerly and accordingly send their patients to the tuberculosis clinic for verification of the diagnosis. It is still too early to say that there is an attitude of enthusiasm for the program, but there is evidence of great improvement.

A pneumothorax clinic is only one essential to a modern antituberculosis campaign; a sanatorium liaison is always needed. Because of the limited number of beds available, prompt hospitalization is not always possible, but there is an unofficial cooperative plan between Flint-Goodridge Hospital and Charity Hospital, where most of the tuberculosis beds are, that Charity accept our seriously ill patients.

Another important feature of the tuberculosis clinic is the function of the public health nurse who works with the doctors in educating the patient and his family. Each new patient is given a fairly comprehensive verbal explanation of what is expected of him. This is followed with a duplicated sheet of instructions in simple language. As the patient improves, he is given supplementary instruction and another sheet of directions. These duplicated sheets, all written in simple language by one of the staff members, are graded from 1 to 8, varying from complete bed rest to resumption of work.

Blackout Precautions

HERE are a few practices that might be of value to other hospitals in solving their blackout problems.

1. Take a sensible look at the entire problem and follow this with a careful analysis of what might be termed critical areas. Critical areas may be defined as those places in the hospital where activities must continue and lights must be on no matter what is happening outside. So-called critical areas are operating rooms, emergency accident rooms, delivery and labor rooms, stairwells between floors, corridors in nursing locations and nursing workrooms. Be sure that the analysis is made by three or four people.

2. Look over the present curtain situation. If the colored curtains do not overlap the casings, paint the outside with a special type of paint and paint a three, four or five inch black strip right around the window glass itself to act as a light seal.

A formula we have found to be practical for painting the outside of light colored curtains is:

1 gallon P & L pine green
1 pound of floor wax or beeswax

Dissolve wax in turpentine. Mix with pine green. Stir thoroughly. Thin with turpentine to make two gallons. After mixture is well stirred and flows easily, stir in one half pint Japan dryer. Hang shade so it will clear the floor. Paint one side only. Brush on evenly and slowly. Dry for at least ten hours.

3. Look over the lighting circuits carefully. Attempt to get as many of the so-called critical areas as possible on a separate circuit so that all lights outside the critical areas can be turned off by master switches. If this is impossible, work out a set of instructions for those in charge of each nursing location and other important work spots, specifying exactly which lights are to be turned out in the event of a blackout warning.

Albany Hospital, an institution of 600 beds, has made complete blackout provisions with an expenditure of only $400.—E. W. Jones, *Albany Hospital, Albany, N. Y.*

Morale in a Psychiatric Hospital

WILLIAM C. MENNINGER
Director, Menninger Sanitarium, Topeka, Kan.

IN PEACE or in war, thoughtful consideration of the methods of building and maintaining morale in any organization is pertinent. However, now that we are faced with the loss of physicians and nurses and with a continuous drain on and turnover of personnel, special consideration should be given to the morale within the hospital.

Morale depends fundamentally upon the relationship between a group and its leader and the understanding and belief in a common purpose. Methods of establishing good morale vary with each institution; they may vary with the size of the hospital, the complexity of its particular problem, the availability of resources, both human and material. The secret in all cases, however, is probably the maintenance of a close understanding contact between the medical director and all departments and, through them, with the entire personnel.

Although this is an individual problem for each institution, it may be of some value and help to know what methods have been utilized at the Menninger Sanitarium for the purpose of building and maintaining a morale comparable to that in a well-adjusted family.

1. *The development and use of a manual of organization.* Such a statement of policy is required for approval by the American College of Surgeons. In our own plan of operation we found that it became absolutely necessary to set forth our policies, organizational plan and procedures. Our original rules were recorded in what we designated as the *Manual.* This is being revised and amplified constantly. It has become the institution bible available to all for ready reference, setting forth the generalities and details of the functions of every administering individual, of every department, every procedure, every policy in the institution. It is consulted frequently, is revised by experience and is one of our chief methods of prophylaxis against misunderstandings.

2. *The promotion of intellectual growth.* This can be accomplished only if plans are continuously in operation to provide for it. We maintain a many-faceted educational program in psychiatry for the staff physicians, the nurses, the therapists, the student nurses, the attendants—in short, for everyone connected with the institution. It is our assumption that a better grasp of psychiatry enables the individual more effectively to comprehend and apply the united purpose of the group—the treatment of patients. Consequently, classes, staff conferences, seminars, guest speakers, literature reviews, case studies, group conferences on patient problems are all regularly scheduled.

For the psychiatric hospital's own sake it needs to combat public ignorance, to raise its standards and to fight for its ideals; in so doing it strives for better medicine, for better service, for self-improvement and for good civilian morale

To foster the educational program, a scientific library is maintained, open only to the employes, and is directed by a full-time librarian. A biweekly library bulletin of new acquisitions and abstracts is printed. As a continuous source of stimulation for study and research and writing, a medical bulletin is published, with occasional entire issues devoted to and contributed by one department in the hospital.

3. *The delegation of authority.* Whenever it is practical, departments within the hospital are established, with carefully chosen individuals placed in charge and authority delegated to those individuals. The departmental head is responsible for the organization of his department, its operation, the management of problems that arise within his group. Rarely are his plans vetoed and never are his suggestions ignored. The importance of this delegation of authority and its support by the medical director can be an extremely important factor in the maintenance of morale. One must guard against an ill-chosen departmental head, as well as against trespassing on the delegated authority or failure to support that authority.

4. *Frequent consultation with departmental heads.* Regularly scheduled individual conferences are held between the medical director of the institution and each of the departmental heads for consideration of department successes and failures, plans and problems. Every week a specified, regular time is scheduled for this conference with the head of the recreational therapy department, with the individual in charge of women's and men's occupational therapy, with the director of educational therapy, with the supervisor in charge of the postgraduate course in psychiatric nursing; daily conferences are held with the director of nursing. Once a week a group conference is held by the medical director with all of the supervisors, therapists and the dietitian.

5. *Information regarding the organization furnished all employes.* Although our group is comparatively small, with 140 employes, we find it helpful to publish a house organ in order to reach every individual with news about other members of the

From a paper presented at the meeting of the Central Neuropsychiatric Hospital Association, Chicago, March 19, 1942.

staff, events occurring within the group that might otherwise come to the attention of only a small number, as well as general notices about policies, reports of conventions, regulations, visitors. The report of the National Research Council on "Fatigue of Workers and Its Relation to Industrial Production" especially stressed the importance of intercommunication to morale in the organization.

The council's report points out that reports upward are usually well developed. In our type of work these are the nurses' charts, the therapists' reports, the business department's statements. Often the communications from the officials downward are fair, though directed to single individuals. Cross-communications between groups or individuals in different departments often do not exist. The report stated that when communication both upward and downward is good, satisfaction is high and authority, strong.

On the basis of this, our bulletin has been published every two weeks for the last eighteen months. The contents are arranged in chronological order. Although the librarian edits the bulletin, the staff, therapy, administrative, business, kitchen and garden departments each has a reporter. This bulletin has been an effective method of distributing information.

Joint Projects Help

6. *Joint research projects.* Projects shared by various members of the staff is another method of building morale. At the present time 17 members of our medical, nursing and therapy staffs are collaborating to compose a manual of psychiatric hospital therapy. Several pieces of joint research work are in progress between the medical staff and the occupational therapy staff, between the medical staff and the psychologists. Such mutual undertakings bring the individual workers to a better understanding of each other and the work itself is a stimulus to growth.

7. *Establishing a sense of fair dealing.* It is the employer's responsibility to establish those policies and practices that will assure the employe an attitude of fair play and consideration. Certain policies can be established, such as specifying the working hours, the responsibilities of each person, the available avenues for expressing dissatisfaction, agreements relative to dismissal or resignation. All of these and other provisions for the regulation of the interpersonal relationships are desirable. Much more fundamental, however, are the employer's friendliness and personal interest in every member of the organization. Such a spirit is contagious; it is adopted by the departmental heads and eventually by every individual. In our own organization the feeling is something akin to that among members of a family, so that a call to the draft or the birth of a new baby is an important event. This close feeling of unity and friendliness is the object of comment by many of our patients and visitors.

8. *Creating a common idealism.* As was indicated in the foregoing, we plan a program of continuous education. This, however, is quite different from the establishment and maintenance of ideals—ideals in our relationships to one another, our ideals of self-improvement and, most important, our ideals in the utilization of scientific treatment measures. The creation and pursuance of ideals must be initiated by the leaders, but once established their inculcation into every individual is a slow but sure result. An immediate result is the attitude that each employe has an interesting and challenging occupation rather than merely an eight hour a day job. He is interested in knowing more about his job and in learning ways to do it better.

Economy Alters Ideals

Our ideals sometimes get us into difficulties because our therapeutic desires sometimes exceed the economic possibilities. As medical director I frequently want more graduate nurses, more therapists, more and better equipment. Not infrequently this attitude is adopted by other hospital physicians and department heads who want to provide the patient with far more opportunities than either the hospital or the patient can afford.

The eight methods listed are concerned with methods of operating the institution and deal directly with the efficiency of the treatment methods. There are, however, other devices or procedures that have been found helpful in maintaining morale, all of which might be regarded as personal considerations or privileges for the employe.

Because economic security is fundamental to morale, much consideration is given to the financial relations among our group. For a time we tried giving automatic increases of salary at stated intervals but because of several disadvantages this plan was discarded. A plan of bonuses was tried, but when the income did not permit their payment, the failure to receive a bonus was too disappointing. Our present plan is to review salaries and possible increases at regular intervals. The result is that most salary raises are granted by the institutional heads before the individuals request them.

Employes Have Insurance Plan

For the older employes, the hospital inaugurated a life insurance program in which the institution pays one half of each annual premium and the employe pays one half. A member of the business department assists in making out income tax statements for all employes who desire such help. The institution encouraged and has aided in the formation of an employes' credit union. Our hospital is organized as a private corporation and as a savings plan employes were encouraged to buy stock, at a discount, with the understanding that it will be redeemed in an emergency. As a consequence, considerable stock is owned by the employes.

Freedom of action in the matter of hours, initiative and personal interests are encouraged among all employes. It has been mentioned that the head of a department has complete authority and management of his department. The great majority of individual employes in consultation with their department heads arrange the time of their vacations. No employe is required or expected to work more than an eight hour day except in emergency situations. Despite the fact that even at the present time graduate nurses in the community work twelve hour shifts, for the last five years our nurses have been on a straight eight hour shift.

Various methods of recognition have been attempted. Each year our hospital holds an "Old-Timers' Dinner," and all the employes who have

been connected with us for three years or longer are invited. Ten, fifteen and twenty years of service are signalized at these dinners. We have always maintained a policy of presenting gifts to all employes on special occasions—at Christmas, at the time of marriage, birth of children and when severing connection with the institution. Special farewell parties are given by various groups or departments for an older employe leaving our service.

Recreational opportunities are also considered and planned for as a means of building morale. A specific budget is set up for certain departments for the purpose of having parties or picnics for the members of those departments. An "Orphans' Party" is held Christmas night for employes away from home. A "Senior Class Dinner" for the student nurses is held for each nursing class. The hospital arranges for special dinners and parties for visiting medical and nursing guests. All employes are encouraged to participate in civic and social groups and activities in the community. Not infrequently staff picnics are held and at frequent intervals private parties of different groups are arranged for by the medical or departmental heads.

A personal health service, both medical and psychiatric, is maintained. Every employe is allotted a certain amount of sick leave each year. Medical services over a short period of time, if they can be provided by the medical staff, are given free of charge and x-ray and laboratory examinations are made for the cost of materials. Rather frequent use is made by various members of the personnel of the privilege of having psychiatric conferences with the medical staff.

All of these methods and devices are helpful in building and maintaining morale but they are of minor importance in comparison with the attitude assumed and the example set by the heads of the institution. If the leader is progressive and scientific, so will his staff be progressive and scientific. If the physician is a student, his staff will follow his lead. If he is merely holding a job to earn a salary, his staff will likely assume the same attitude. The heads of the various departments share this same responsibility to some extent.

When the Resident Operates

What Are the Legal Responsibilities?

EMANUEL HAYT

CHARITABLE hospitals are exempt from liability to patients for the negligence of their medical staffs despite the fact that the hospital selects the attending physician for ward patients.[1] Physicians are not subject to the direction and control of the administrative officers of the hospital with respect to the professional care and treatment of patients; therefore, they do not function as agents of the hospital.[2] Nevertheless, the law imposes a duty upon hospitals to designate physicians who are reputable and qualified.[3]

One of the requirements for certification in surgery is a minimum of five years of special training in that field, beyond one year of general internship. Advanced residencies in surgery offer ward and operating room responsibility to senior residents, permitting them to proceed under the general supervision of the attending surgical staff. In entrusting major surgical procedures to such residents, certain legal responsibilities are assumed.

Residents, like interns, are not authorized to practice medicine outside of the hospital except in connection with their hospital service.[4] Medical practice statutes invariably exempt interns and residents from obtaining state licenses[5] on the theory that they serve as apprentices under the supervision or direction of the attending medical staff.[6]

How much supervision is to be given to a resident depends on his experience and the nature of the surgical procedure. It is sound practice for the attending physician to have the patient's chart contain specific instructions for the resident, when the attending physician does not personally supervise the operation. There is thus provided the necessary "direction."

The absence of the attending physician from the operating room is by no means legal negligence, unless he has assigned to the patient an inexperienced resident or has failed to give proper instructions. In such case the attending physician could be held jointly liable with the resident for any bad results attributable to their carelessness.[7] The bare fact that there was a poor operative result does not indicate unskillful treatment.[8] Neither the resident nor the attending surgeon guarantees a cure, for the law does not contemplate that every operation will be successful.[9]

The mere presence of the attending physician in the operating room does not relieve the resident of responsibility for his own misconduct. For example, if a foreign substance or a surgical instrument were left in the patient's body, both participants in the operation could be held accountable for any ensuing injury.[10]

Since the hospital is obligated to furnish competent medical attention for its patients, it must look into the qualifications of the medical staff.[11] To permit inexperienced residents to perform major surgery is violative of that duty, as is allowing residents to function without the guidance of the attending staff. An M.D. degree and surgical experience may be evidence of the ability of a resident, but they do not dispense with the requirement of responsible supervision. However, a licensed resident may practice without supervision or direction, but if he undertakes to perform surgical procedures for which he lacks skill he may be guilty of malpractice.[12]

[1]Schloendorff *v.* the Society of the New York Hospital, 211 N. Y. 125, 105 N. E. 92.
[2]Arkansas Midland Ry. Co. *v.* Pearson, 97 Ark. 399.
[3]Silva *v.* Providence Hospital of Oakland, 97 P. (2d) 798 (Cal.).
[4]Nickley *v.* Skemp, 239 N. W. 426 (Wis.).
[5]Matter of Rathbun *v.* Smith, 175 Misc. 246 (N. Y.).
[6]Nickley *v.* Skemp, supra.
[7]Nash *v.* Royster, 189 N. C. 408, 127 S. E. 356.
[8]Lippard *v.* Johnson, 1 S. E. (2d) 889 (N. C.).
[9]Pike *v.* Honsinger, 155 N. Y. 201.
[10]Spears *v.* McKinnon, 168 Ark. 357, 270 S. W. 524.
[11]Pepke *v.* Grace Hospital, 130 Mich. 493, 90 N. W. 278.
[12]Hodgson *v.* Bigelow, 7 A. (2d) 338 (Pa.).

Signposts to the Future

From S. R. SPELLER, LL.B.
Editor, The Hospital

London, England
May 5, 1942

DEAR Colleagues in America:

At the outbreak of this war all but the smallest of our hospitals were embodied in or brought into relationship with the Emergency Medical Service. For the first time we had in Great Britain and Northern Ireland a completely organized, if temporary, hospital system.

Certain aspects of the long term hospital policy are emerging, partly as a result of war-time lessons and partly because of other influences. Most of what I ought to say is summed up in a debate in the House of Commons on April 21 in which Ernest Brown, the minister of health, replied.

Need for Regionalization

All parties in the Commons were as one in recognizing the need for organizing the hospital services of the country on a regional basis, though there was division of opinion as to the status within the scheme of the voluntary hospitals, a problem closely bound up with the financial position of those hospitals. It is generally conceded that after the war when the voluntary hospitals no longer receive payments from the E.M.S. they will not receive sufficient income from subscriptions, together with contributory scheme payments, to meet their expenses.

The voluntary hospitals would like this aid to be from central government funds, in the same way as the present temporary aid toward nurses' salaries, and to be administered either through their own central organization, the British Hospitals Association, or through an *ad hoc* body analogous to the University Grants Commission, possibly making its grants to the regional boards, payments to individual hospitals being made by those boards. The hospitals would thus hope to avoid direct interference with their internal government and organization.

On the other hand, as the county councils and county borough councils are to be responsible for seeing that an adequate hospital service is provided and maintained in their own areas, these authorities naturally would desire to be made the channel for grants to voluntary hospitals within their boundaries and to be given the right to impose conditions and demand representation on the governing bodies of hospitals to which grants are made.

The right solution is not easy to find. In the old days when the bulk of voluntary hospital funds were put up by subscribers it was unquestioned that those subscribers should control the hospital. But now in many cases the hospitals are largely supported by contributory scheme payments and by public money and yet the majority control on the board goes to the subscribers of the residue of the current income. Moreover, in effect, the bulk of the subscribers for one reason or another take no effective part in the elections, so boards frequently seem little more than self-elected bodies. This is important to realize, since it is relevant in considering the plea of the voluntary hospitals that governmental or local authority representation would limit their freedom and that, anyway, they are already democratic in their organization.

Until recently the county councils have been keen for change and have been quite willing to see the voluntary hospitals engulfed in a new unified system. But of late, as a result of the war-time curtailment of their own powers consequent on the appointment of regional civil defense commissions, they have shied at any plan having a region as its administrative unit. This was freely admitted in Parliament and was, indeed, the reason for dropping the word "regionalization" in favor of "coordination—on a regional basis"!

Social Insurance Studied

Not unconnected with what I have said is the work of the government committee that is now studying problems of social insurance. Undoubtedly, since the government maintains the principle that hospital services should be paid for by the patient, that committee will suggest methods of public insurance for the bulk of the population. Many of us foresee an extension of the present limited scheme of the National Health Insurance which provides free general practitioner service, but not hospital and specialist treatment, for workers earning up to £420 per annum (increased last year from £250). The scheme does not include their families.

So far, the only possible provision for workers and their families against hospital charges has been through contributory schemes organized by or for the benefit of voluntary hospitals. The schemes have already had to accept the fact that some of their members have to go for treatment to public authority hospitals and in many areas have negotiated financial agreements with the authorities concerned. Nevertheless, since by taking into account the fact that through yearly distribution of surplus to participating voluntary hospitals the local authority institutions do not receive as good a return per contributory scheme patient, it is inevitable that in any new nationally organized scheme the inequality would be ironed out—to the financial disadvantage of the voluntary hospitals.

This brings us naturally to another aspect of social security, viz. workmen's compensation and rehabilitation after industrial accidents. This, too, is a subject exercising the minds of the government committee, a subject that was not overlooked in the parliamentary debate. Briefly, at the present time the maximum weekly payment of 35 shillings for an injured workman is hopelessly inadequate for a man with a family, nor has any organized attempt been made to assure early rehabilitation when practicable.

Focus Attention on Rehabilitation

Until 1939 little attention was given to industrial rehabilitation in this country, though one or two hospitals, such as the Albert Dock, were notable exceptions. Then soon after the outbreak of war the Birmingham Accident Hospital was founded with the support both of the civic authorities and of the industrial undertakings of the Midlands. Meanwhile, various hospitals in the E.M.S. were being set aside for special work, such as brain surgery. In his speech in Parliament, the minister of health said:

"There are certain things about the Emergency Hospital Scheme which, of course, give us great lessons for the future. For instance, we ought to learn the business of grouping of special treatment centers so that we may concentrate personnel, equipment and experience, with facilities for interhospital transfer of patients. We ought to learn to eliminate unnecessary and uneconomical competition in some specialized fields by adjacent hospitals.

"Out of the general experience of the emergency scheme, we ought to learn to correlate the hospitals by a wider conception of hospital service, so that different hospitals, both voluntary and local authority, may give service not only as individual entities but as participants in the service as a whole."

SMALL HOSPITAL *Forum*

AN ACCOUNT OF A VISIT TO SEVERAL SMALL HOSPITALS IN CENTRAL AND SOUTHERN OHIO

REPORTERS: Mildred Whitcomb and Jane Barton

Future Nurses Receive Preliminary Training as Ward Aides at Findlay

A ward aide system that is designed to benefit the aides as much as it benefits the hospital was established by Mabel F. Pittman, superintendent of Findlay Hospital, Findlay, Ohio, as long ago as October 1936.

On the theory that education begins at home, Miss Pittman offers high school graduates who want to enter the nursing profession a year of practical training as ward aides before they embark on their chosen career.

Aides are selected with great care. Every year twelve 18 year old girls who have maintained at least a B average throughout high school and have had four years of English are chosen. Those who have not taken the fourth year of English are requested to take it in a postgraduate course.

The training includes two hours of theoretical instruction a week in addition to practical work in preliminary nursing,

(*Continued on page* 64)

Poliomyelitis Patients May Apply Here From Now On

Van Wert County Hospital had to refuse care to an infantile paralysis patient because it had at the time neither suitable isolation quarters nor a respirator.

Following that incident matters changed rapidly. One end of each of the two sunny wards was converted into isolation quarters by means of a demountable partition built up of plywood and opaque glass. Running water was installed in each room.

When the two rooms are not needed for isolation purposes, down come the partitions in a twinkling of an eye or, rather, in five minutes. It cost $200 to erect the partitions.

A good citizen heard the superintendent's story of the regretted refusal of the case. He donated $3000, anonymously, for the latest type of respirator that will accommodate one adult or two child patients, for an infant respirator and for a resuscitator.

Since their purchase last fall there has been no call for the services of this equipment.

Portrait of Ohio's Smaller Hospitals May Indicate Current Situation on National Scale

WAR SAVES MANY LIVES

War is saving lives as well as taking them.

You don't have to wait for 1942 figures from the National Safety Council; you merely need to visit the small town hospitals of the nation where well-arranged and usually overstrained emergency departments are lying idle many hours during the day and night.

Ohio has no gas rationing but the tire shortage and the call for patriots to reduce their speed limits to conserve rubber and gasoline have had a heartening effect on the number of motor casualties.

Less traffic and slower driving are two factors in reducing highway accidents, but there is a third with an equally beneficial effect. The draft has taken the younger men, including many speed demons, show-offs and drinking drivers, and highway travel is safer.

Another war note is the avidity with which passenger cars give most of the road to those great trucks labeled in scarehead capitals "EXPLOSIVES."

Collisions at crossroads now constitute about 75 per cent of highway accidents in Ohio.

If we take Ohio as an index of the national situation, what is the picture in our smaller hospitals as of late May 1942? Here is a generalization based on visits to five institutions:

1. The nursing shortage is acute. Hospitals are getting along only reasonably well despite the assistance of the first crop of Red Cross nurses' aides who are supplementing long experienced nurses' aides of the hospitals' own training. Private duty nursing is fading into insignificance.

2. Occupancy continues very high, notably in the maternity department. Recently remodeled nurseries are overflowing. What was once pointed out as a "fathers' room" is now just another mother's room, as are the sun porches.

3. Emergency cases are off, as is pointed out in the adjoining column.

4. Loss of doctors to the armed services is an immediate threat but so far has depleted the staff but little. Some of the best surgeons, oto-laryngologists and orthopedic men are slated for early departure, however.

5. Civilian defense is fairly well organized, with hospitals physically prepared for catastrophies, particularly in areas with defense plants or near large cities where evacuation of patients is contemplated in event of major disaster.

(*Continued on page* 64)

Improvise for Civilian Casualties When Local Hospital Is Overcrowded

As every one of Memorial Hospital's 78 beds and 12 bassinets is likely to be needed to meet the day-to-day demands of citizens of Piqua, Ohio, the local civilian defense council was hard put to it when planning its emergency medical services.

Five citizens of the community recently bought an old mansion near the hospital and have turned it over to the city for use as an emergency hospital. It is fitted up with Red Cross beds and supplies.

The Red Cross nurses' aides will probably be called upon to carry the full burden of nursing in the emergency hospital, should a disaster befall, as Coral M. Page, superintendent of Memorial Hospital, cannot spare a single nurse from her war depleted staff.

Hollywood Première Nets Women's Auxiliary $250

Had you thought of a "Hollywood première" as a money-making scheme for your women's auxiliary? The good ladies at Greenville, Ohio, recently cleared $250 on such a venture at the local theater.

Local citizens who showed striking or even slight resemblance to movie stars were drafted for the performance. They swept into the theater in glamorous garb; strode or glided across the stage while the cameras clicked, pausing at the microphone to speak a typical Hollywood greeting, and then, amid terrific applause, filed off into the audience where they watched the movie and some variety acts by local talent. Wayne Hospital, of course, is the beneficiary.

If Disaster Comes, Van Wert County Hospital Won't Be Caught Napping

Van Wert, Ohio, is not expecting an air raid and, being primarily agricultural, it isn't subject to great danger from sabotage. But Van Wert County Hospital is not taking any chances. If disaster comes, it won't be caught pearl-harboring.

This 44 bed institution can accommodate 85 beds, if necessary. It has the beds and it has the emergency equipment. Those 11 bed wards with their cross ventilation and great ceiling fans can take 18 beds without undue crowding. Private rooms are large enough to accommodate two or three beds, if necessary.

In one corner of the nurses' dining room adjacent to the emergency department stands an emergency cabinet, a duplicate of one in the emergency department itself. It contains enough instruments for six cases; the solutions stand ready; sterile supplies are on hand.

The plan of receiving emergency cases is well worked out. Boards have been stained and mattresses are ready to be placed over small tables in the dining room to set up a second emergency room. This means that a full dozen patients can be given treatment in the ground floor rooms, while the newly equipped surgical suite on the top floor is taking care of the more seriously injured patients.

The local Red Cross has made drums to hold complete emergency equipment and sterile dressings for first-aid stations in the armory and high school. Kathryn Schmidt, surgical nurse, sterilized all of these dressings along with those included in 14 containers assigned to the centralized elementary schools in the county.

Nurses' Dining Room at Findlay Is Designed to Stimulate Appetites

If Findlay Hospital nurses don't have good appetites it is not the fault of their environment—or the food, either. Maple tables and chairs, the latter covered with rose colored leather, flowers on the tables and a corner cabinet containing antiques (Miss Pittman is an enthusiastic collector), all combine to make a homelike and charming effect.

The painting on one wall has a history all its own. A member of the medical staff presented Miss Pittman with $10 to buy candy for the nurses just before he went away on a vacation. Instead, she used it as partial payment for the picture. When the donor returned and learned what had become of his $10 he approved so highly that he paid for framing the painting.

The best part of the story lies in the method of obtaining the funds to furnish the room. Miss Pittman cast a speculative eye on a large assortment of outmoded and unused bathtubs, old furniture and piles of papers that were cluttering up the corners of the basement and then went into the secondhand business, with such gratifying financial results that the nurses' dining room became a reality much more quickly than anyone had hoped.

Stars Dress up Floor

Want to dress up your linoleum floors without much expense? Try this one. At Findlay Hospital big white stars have been inlaid in the linoleum floors of several rooms. The effect is distinctive and the old floors look like new.

OHIO HOSPITALS VISITED

Findlay Hospital, Findlay, 76 beds.
Memorial Hospital, Piqua, 78 beds.
Post Hospital, Patterson Field, Fairfield, 65 beds.
Stouder Memorial Hospital, Troy, 52 beds.
Van Wert County Hospital, Van Wert, 44 beds.
Wayne Hospital, Greenville, 47 beds.

Guarding Against Fire at Night When Staff Is Small and Female

Like many small hospitals in other states, women constitute the entire night staff of Van Wert County Hospital. What if fire should break out; would they be able to cope with it until the local fire department arrived?

Supt. H. M. Gee is satisfied that this hospital is safe for, in addition to a system of fire hose hooked in with the city water pressure system, he has installed two types of auxiliary fire-fighting apparatus.

In strategic points about the hospital, usually on the frames of doors, hangs a round glass container filled with red liquid. The nurse, if fire breaks out, seizes one of these carbon tetrachloride extinguishers and hurls it like a grenade at the flames. As a secondary precaution in utility rooms over the gas burners and in like locations, another type of tetrachloride extinguisher has been installed. It has a soft lead fuse which melts and helps to extinguish fire.

Portrait of Ohio's Smaller Hospitals May Reflect Nation's

(*Continued from page 63*)

6. Freezing orders and shortages in equipment find hospitals well stocked, with enough material on hand for another year's operation with careful handling. The only actual shortage encountered—and it was but temporary—was in the vital item of safety pins. (All is now well on the nursery front, or should we say "rear"?)

7. Dietitians have the sugar rationing (a 50 per cent cut from last year's supply) well in hand and by the use of saccharine, honey and corn syrup are managing to turn out desserts every bit as delectable as of old. Coffee and tea shortages have brought no embarrassment as yet. Hospital food is definitely good, with female cooks preponderating.

8. No hospital visited failed to display with pardonable pride some brand new major items of equipment, such as an "iron lung," G. U. table, surgical tables, new beds and mattresses, that have been purchased during the past year.

9. Lighting problems, both natural and artificial, have been getting particular attention. Glass block areas in the surgery, venetian blinds in offices and patients' rooms, emergency lighting for operating rooms and delivery rooms, fluorescent lighting in offices, laboratories, record rooms and often in dining rooms, these were observed in most institutions.

10. Next to the nursing problem, which is acute and in one hospital visited actually desperate, are the familiar perplexers—getting medical records up to date and keeping the trustees aware of and confined to their proper functions.

11. Administrators in each instance are keeping up with the professional bandwagon by attending institutes and conventions and by visiting near-by hospitals to share experiences.

Future Nurses Get Training as Ward Aides at Findlay

(*Continued from page 63*)

such as bedmaking, giving baths and feeding patients. This work is closely supervised by the graduate nurses.

Aides are paid 15 cents an hour for a forty-eight hour week and, in addition, are given full maintenance and free uniforms.

After a full year of such training, it is no wonder that these girls enter nursing school with a long start over their fellow students, and no wonder either that Miss Pittman beams pridefully when she speaks of the excellent records made by her protégées, four of whom, by the way, have come back to Findlay as members of the graduate staff.

THINKS IDEA WORTH TRIAL

While some superintendents will defend to the death those bronze plates over the doors of rooms naming the donor, others find the custom depressing.

One Ohio superintendent has hit upon a substitute scheme, which is now in its first stage. The donor's name is written in a flowing black script on parchment or fine paper stock and this small acknowledgment is placed in a small frame of natural colored wood with a narrow red molding at the inside edge. The little framed acknowledgment is hung on one wall of the room furnished by the donor.

The second stage will come when the little frame and its contents are some day consigned to oblivion or to possible quick resurrection by being placed in the top dresser drawer.

Refrigerator That Wasn't "Frozen"

Although Findlay Hospital does not have a pharmacist, any pharmacist would be happy to work in the modern, well-lighted drug room there. Ample cabinet space is provided, in addition to a shining new biological refrigerator (which arrived just before the government order froze such equipment). Drugs are issued by the operating room supervisor. Prescriptions for the hospital are made up at the local drug store.

Has Complete Auxiliary Lighting

Uninterrupted service to patients is promised by Van Wert County Hospital, Van Wert, Ohio, in the case of failure of the lighting system. The alternate lighting system consists of a 60 cell battery plant which can carry the entire lighting load of the hospital for forty-eight hours. The secondary system does not operate the elevator or the stokers.

Less Coffee, but Just as Good

Dietitians, please note: Patients at Findlay Hospital will continue to drink good coffee, even though they cannot have as much as they used to. This decision was arrived at by Mabel Pittman and her dietitian in the course of a discussion of the coffee shortage. The alternative of making weak coffee and serving several cups was firmly vetoed.

Half Doors Afford Coolness

Half doors on the patients' rooms at several Ohio hospitals are covered with curtain material instead of being solid. This arrangement has proved eminently satisfactory since it combines privacy with comfort, especially on hot summer days.

A Bed of Roses? Not Administration in this Understaffed Institution

"With a modern building and a handsome endowment I could run a successful hospital, too," some envious reader is going to remark.

Envious Reader, consider the situation at Memorial Hospital, Piqua. True, a year ago it opened a well-equipped surgical suite on the third floor and the old surgery came in for some remodeling and adaptation to new uses. A proud job, it is! But—

Look at the old main section. Redecorating time is long past, paint is procurable but labor—not at any price in Piqua.

Is it war or is it hospital insurance that crowds the maternity department so that 21 mothers are delivered of infants for which there are 12 bassinets?

Memorial Hospital has high nursing standards which it zealously strives to maintain and 30 general staff nurses are considered adequate for its 78 adult patients' beds. Patriotism and profit have claimed many of these for the armed services and for industrial and public health nursing.

Yes, the town has been combed. The married nurses are all working. Appeals for more R.N.'s have gone out to six nursing employment bureaus. Yet only 22 registered nurses are on hand to serve a crowded house. They work longer hours because they won't see sick men and women neglected. They sacrifice hours off and half days off in the hope that help may be on the way.

A surgeon's wife with heavy home responsibilities can't do much beyond her present undertakings but she volunteers to work on the wards on Saturday and Sunday evenings so that weary staff nurses can get a little rest and change.

Proud new graduates of the Red Cross nurses' aide course labor industriously, although necessarily restricted in duty.

The hospital's own nurses' aides, high school graduates some of whom have been with the hospital for years, take temperatures now and give general care to patients.

"Our experienced nurses' aides may have to be taught to scrub in the delivery room," explains forceful Coral M. Page, the superintendent, who is highly commended throughout the state for her fine administration and who is eager for ideas on how other hospitals are functioning in like predicaments.

Hospital administration in war time is going to be full of such emergencies; the Piqua situation may be duplicated in any community six months or a year from now. A less courageous and experienced person than Miss Page might well be downed by such a crisis, but Miss Page will carry through. Piqua counts on her and delayed decorating, overcrowding and understaffing will some way be survived and surmounted.

Army Post Hospital Opened in May

Patterson Field, the Army air depot near Fairfield, 12 miles northeast of Dayton, opened a new 65 bed post hospital in late May. This is a permanent three story building with the latest equipment and several unique features. Major Neece is the surgeon in charge. This hospital is not discussed in this presentation, owing to the fact that its problems differ from those of most small civilian hospitals; however, the hospital building will be described in full in a later issue.

Emergency Suite Is Prepared to Meet All Contingencies

Emergency cases at Findlay are cared for in a well-equipped suite that opens off of the ambulance entrance. The admitting clerk in this department has her office in a small room that commands a view of the entire suite so that she can see everything that is going on and can obtain additional help from the surgery if it is needed. When those giving emergency treatment need to provide the patient with privacy a blind is drawn over the clerk's viewing window.

Another feature of the department is a small but pleasant waiting room where friends or relatives of the emergency patients can wait in comfort while treatment is being given. This arrangement works to the benefit of both the hospital and those who are waiting, inasmuch as they are not standing around obstructing traffic.

Emergency Water Supply

Just in case something should happen to the town water supply, Van Wert County Hospital has been equipped with two 1000 barrel cisterns, which will be a great help in tiding the institution over until the regular water service is functioning normally.

Ladies Board Numbers 54

Upkeep of the Van Wert County Hospital and nurses' home is supervised by a ladies' board of managers of 54 members. Of these 18 are from the city of Van Wert and three are from each of the 12 townships in the county.

Exponents of Graceful Living Found Among Small Hospital Administrators

Small hospital superintendents don't lead the cloistered lives that legend or tradition has it. When it comes to genteel living in charming surroundings some northern Ohio superintendents could give pointers to professional men and women in metropolitan areas.

Take H. M. Gee, superintendent of Van Wert County Hospital. He lives in a rambling white country residence situated in parklike grounds and surrounded by gleaming white fences. He remains at the hospital through the dinner (or supper) hour but following that he motors out through the peony and iris gardens of that vicinity to spend the long daylight hours of evening about his grounds and stables.

Mabel F. Pittman of Findlay Hospital steps into another world without even going out of her hospital. Triple walls separate her tastefully decorated suite from the sounds of the institution. Her charming living room would grace any magazine of home decoration with its blending of 18th century English furniture with American antiques.

Miss Pittman collects glass, china and figurines. Built-in cabinets, hobby tables and her own dining arrangements fittingly display her collections. She has a beautifully equipped electric kitchen and a good sized, artistically decorated bedroom, where she recently was forced to spend some weeks as a patient. She wanted to occupy one of the patients' rooms to save nursing time but her physician was too impressed with the therapeutic value of such delightful surroundings to permit the move.

As Pretty as They Come

No prettier private room could be found anywhere than the room recently redecorated and refurnished by the ladies' auxiliary of the American Legion post at Van Wert County Hospital. Peach walls, white woodwork, draperies of flowered chintz with a green background, venetian blinds, chenille bedspread and painted metal furniture make the room much sought after by patients. The fact that the room has windows on three sides gives it a natural advantage as well. It rents for $6 a day, in case you're interested in Van Wert's best accommodations.

Oxygen Tanks Stored Safely

Oxygen cylinders are bulky, awkward and much in the way unless they are properly stored. An ingenious method of storing them has been developed at Findlay Hospital to overcome these difficulties. The hospital engineer constructed two cabinets—one for new tanks and one for empties—fitted with compartments just large enough to accommodate a cylinder. The compartments are slightly tilted to facilitate the removal of the tanks.

"The Song of the Stoker"

For versatility, we recommend one Ohio hospital's man Friday. In ballad form, his achievements would be recited under some such title as "The Song of the Stoker." Blank Hospital's man Friday has been so emancipated from janitorial duties by the installation of two stokers that he combines orderly's tasks, laundry management and "preps" for surgery with his plant operation and maintenance duties.

Smartly Decorated Lounge Pleases Greenville Doctors

Found: A newly decorated doctors' lounge without red leather chairs. The color scheme is blue and yellow at Wayne Hospital, Greenville, where in the new section a smartly turned out lounge provides every comfort for the doctor with a few minutes of leisure for a bath or smoke.

The tubular steel chromium plated furniture is upholstered in primrose and canary yellow both of which are complemented by the bold blue linoleum covered floor. Draperies are in a rayon fabric with yellow, beige, orange and brown vertical stripes, a design so pleasing that Christene Evans, the superintendent, has used the same pattern for her own trimly efficient office.

These Aides Had Nurse Training

Instead of using as ward aides girls who want to become nurses, as is the case at Findlay Hospital, Katherine Hennessey of Stouder Memorial Hospital, Troy, employs girls who were once in nurses' training but dropped out for one reason or another. She now has seven such aides in the hospital and feels that their knowledge of nursing is a great asset in their work.

Clothes Go Home for Duration

Being cramped for locker and closet space, Wayne Hospital, Greenville, sends the clothes of all ward patients home during their period of stay. When accident cases are brought in, the nurses' aides bring out a clothes box, pack the garments carefully and send them home in care of one of the relatives.

Three Reasons Explain Contentment of the Staff Nurses at Greenville

Her time may be coming but so far Supt. Christene Evans of Wayne Hospital, Greenville, Ohio, has not lost the number of nurses that other hospitals bemoan.

Possible explanations include: a democratic setup in which the nurses have little apparent supervision, liberal arrangement of free time and the attractive lounge and smoking room provided for the nurses' convenience.

The general staff nurses have a full Sunday off every other week. This full holiday they alternate with a half day off on the succeeding week.

The nurses arrange their time off among themselves, post the half day and Sunday schedule on the bulletin board a week in advance and glory in their full day's liberty and absence of administrative domination. Of course, the nurses left on Sunday duty must work extra hard but that comes easier at the thought that the next Sunday is a free day for them.

In Wayne's beautiful new building, opened last year, is a small lounge for the nurses just off the surgical suite. Nurses working a split shift may retire to their own little club to relax in the chintz covered lounge chairs or to lie upon the tailored day bed. There is a coffee table for magazines, cool drinks and ash trays and adjoining is a private toilet with colored plumbing fixtures, all much in the spirit of a metropolitan women's clubhouse.

Doctors Learn From Necropsies

Believing that necropsies have an important educational function, Mabel F. Pittman of Findlay Hospital has provided a small amphitheater in the autopsy room so that staff members can witness this work and discuss the various cases. A raised platform that holds six chairs has been built along one wall so that the doctors can see what is being done without getting in the way of the person working at the table. Two steps lead up to the platform so that long-legged medical men don't sit with their knees up under their chins.

Auxiliary Furnishes Nursery

A $1000 gift from the women's auxiliary furnished Wayne's beautiful new nursery. While the auxiliary's membership is 125 women, this by no means represents the woman power behind this 47 bed hospital. Clubs, granges and church groups in the county bring the number of women workers up to 400 or more.

WORK BENCH ON WHEELS SERVES SURGICAL NURSES

A surgical supervisor's dream of efficiency came true in the work bench on wheels that Supt. Christene Evans of Greenville designed for the operating room of the new Wayne Hospital.

Four deep drawers extend the width of the table and can be pulled out from either side. The oval top is covered with marbleized composition material that can be wiped clean with a damp cloth, and at either end of the bench are shelves for storing small items.

Mounted on swivel casters, the bench can be moved easily wherever it is most needed—and it is needed much of the time.

The sketch above is not exact; dimensions may be had from the hospital.

When It Comes to Fine Equipment, Van Wert Has Much and Modern

It may be housed in a 65 year old former schoolhouse—although we defy you to guess it—but Van Wert County Hospital boasts as fine equipment as any hospital in Ohio, regardless of size or area.

Most of this equipment has come through the endowment fund built up through large bequests and gifts to the local hospital. Although a county hospital in name, the hospital receives no support from the county, this unit of government merely reimbursing the hospital for ward care for indigents and that at a rate less than the actual cost.

Ward rates are $3.50 a day and private room charges are from $4.50 to $6 a day.

Most of the equipment is new. H. M. Gee, the superintendent, is a specialist in purchasing, his previous business connections with Marshall Field & Company and other merchandising concerns having given him great interest and knowledge in that field.

The nursing activities of the hospital are directed by Mabel F. Felger, an executive of experience in large Pennsylvania and Ohio hospitals and nursing schools.

Morticians Build Good Will by Courtesies to Public and Staff

Morticians in two Ohio towns, Van Wert and Greenville, believe in the value of obtaining the good will of the local hospitals.

Patients in Van Wert who need ambulance service have only to call the mortician and they are promptly and cheerfully transported to or from the hospital without charge. Both the patients and the hospital staff are pleased and grateful for this service.

At Greenville the morticians furnished a handsome lounge—all done in yellow leather—for the medical staff at the time the new hospital was erected.

No Payment in Advance

Payment in advance is *not* the rule at Van Wert Hospital.

"It isn't very humane to demand that patients pay us before we will care for them," argues H. M. Gee, the superintendent; "besides, we know our people."

That humanity pays is attested by the fact that collections are generally good. Of course, there are always a few who take advantage, but most people appreciate the hospital's attitude and do their best to pay promptly and in full.

No More Free Phone Calls

Wayne Hospital's switchboard at Greenville will be considerably less busy beginning July 1, if Supt. Christene Evans' plans go through. Now private patients have bedside telephones and no accounting is kept and no fees are charged for telephone calls. At 25 cents a day for telephone service, she expects considerable less chatter over the wires. For those who pay the fee for telephone service, no limit will be placed on the number of outgoing calls.

Medical Representation on Board

One of those half-doctor, half-layman boards occasionally found serves Wayne Hospital, Greenville. Each service is represented on the physician branch of the board and the doctors rotate their membership. Attendance at monthly board meetings averages 75 per cent and interest runs reasonably high.

Forerunner of Peony Festival

Van Wert's famed peony parade, omitted this year because of the war, had its spiritual ancestor in the flower festival of 1906, funds from which started the Van Wert County Hospital Association.

Repainting Makes Old Office Furniture Resemble the New

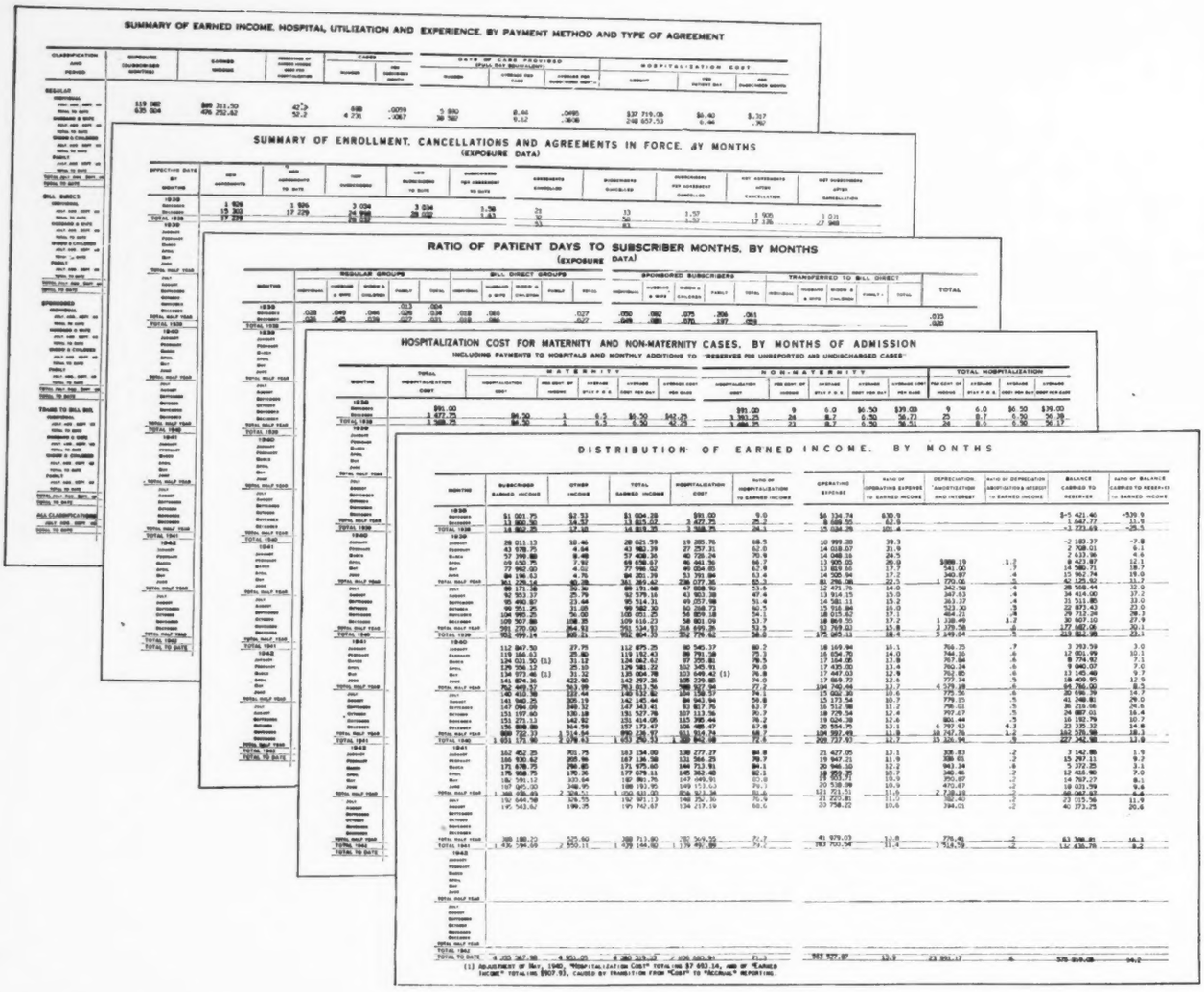
For trim, businesslike efficiency you won't find a better office than Supt. H. M. Gee's of Van Wert County Hospital. An impressive battery of steel filing cabinets is finished in battleship gray, as are desks, wastebaskets and other appurtenances. You think to yourself that Mr. Gee has junked all his old furniture and files and started in anew.

Nothing could be farther from the truth. When new files were needed, Mr. Gee bought the gray files. From the manufacturer he ordered the necessary quantity of matching gray paint to transform the old olive green desks and files into a military type of conformity. A local man did the spray painting.

Apple Blossoms All Year Round

An artist nurse is an asset to any institution, as Findlay Hospital has discovered. When the nurses' alumnae group endowed a room in the hospital, Miss Pittman asked one of her nurses with artistic leanings to decorate it. Now, patients in that room gaze on a wall where sprays of apple blossoms bring springtime inside no matter what the weather man has to say.

Blue Cross Reporting Made Clear


SUMMARY OF EARNED INCOME, HOSPITAL UTILIZATION AND EXPERIENCE, BY PAYMENT METHOD AND TYPE OF AGREEMENT

SUMMARY OF ENROLLMENT, CANCELLATIONS AND AGREEMENTS IN FORCE, BY MONTHS (EXPOSURE DATA)

RATIO OF PATIENT DAYS TO SUBSCRIBER MONTHS, BY MONTHS (EXPOSURE DATA)

HOSPITALIZATION COST FOR MATERNITY AND NON-MATERNITY CASES, BY MONTHS OF ADMISSION INCLUDING PAYMENTS TO HOSPITALS AND MONTHLY ADDITIONS TO "RESERVES FOR UNREPORTED AND UNDISCHARGED CASES"

DISTRIBUTION OF EARNED INCOME, BY MONTHS

THE Blue Cross story is a story in "numbers" of the dollars earned and saved by subscribers, of the number of hospital stays, the number of babies born to subscribers of the plan and countless other such facts.

One of the contributing factors in the success of the Blue Cross plans has been public confidence. Plan managements have consistently provided the public with the story of their successes and failures. That the public is interested in financial and statistical data has been proved time after time in the operation of these plans. That the support of the public becomes more meaningful as it is informed is obvious.

Comparison of the performances of hospital service plans is an entirely different matter. Here, special knowledge is required of the plans to be compared, the number of years they have been in operation, the kinds of areas in which they are operating, details of their contracts with subscribers and hospitals, the reporting base of financial and statistical data, and the definitions of terms used. Plan performance in enrollment, operating costs and hospital utilization will vary greatly by areas. Gross figures for comparative purposes are almost valueless.

This series of tables, including three others not shown, is brought up to date each month and presented in a leather bound brief case to each member of the finance committee of the Philadelphia plan. Thus, the directors can see quickly all significant facts about each month's performance compared with earlier periods.

It may be observed that some plans have larger reserves than others, but the comparison of reserves is almost valueless unless the number of subscribers protected by reserves is taken into consideration and unless the items included in reserves are of the same relative value. Certain plans include as reserve funds what other plans regard as allocated liabilities. Such an important item as a reserve for unreported and undischarged cases, while it appears on certain plans' balance sheets, may not appear on others. When this liability is not acknowledged, it is also generally true that accounts receivable has not been listed as an asset, it being held that the contingent liability offsets the contingent asset.

In the same way, certain plans do not now report unearned premium income except as a reserve. Since

E. A. VAN STEENWYK

Executive Director, Associated Hospital Service of Philadelphia

such funds represent advance payments made by subscribers, they are only held by the corporation pending earning in subscriber accounts. A distinction must therefore be made between surplus and nonsurplus reserves if accurate comparison is to be made.

Certain plans operate and report on the basis of cash receipts. Earnings are derived from receipts and the entire financial structure must be interpreted on the basis of receipts. Other plans report on the accrual basis. Under this system, earnings statements are derived from exposure to risk of the number of subscribers, after proper deductions have been made for cancellations.

Still another procedure is sometimes followed by plans which report partly on cash receipts and partly on the accrual basis. Maintaining a consistent reporting basis is difficult when using this method. The different bases for reporting indicate some of the problems that must be met in analyzing the experience and performance of individual hospital service plans.

The problems of plans are not unique—hospitals and other organizations have for years tried to obtain agreement upon nomenclature of both financial and statistical terms. These differences reflect the differences of temperament of administrators and the differences in local needs, but unless understood they lead to grossly inadequate snap judgments. This is just one of the many jobs that have been undertaken by the Hospital Service Plan Commission office. That its work has been successful is apparent in the kind of over-the-country reporting it is now able to do. The work of the commission office, aided by the various committees selected for this purpose, has been eagerly supported by most plans.

Hospital service plans are now big business. Their transactions are so numerous and the kinds of subscribers they have enrolled are so varied that it is impossible to judge the performance of a plan without knowing its history, the provisions of its contract, its enrollment regulations and all factors concerning its reporting base. The need for informed opinion in the board of directors and for understanding on the part of the public has never been as great as it is today.

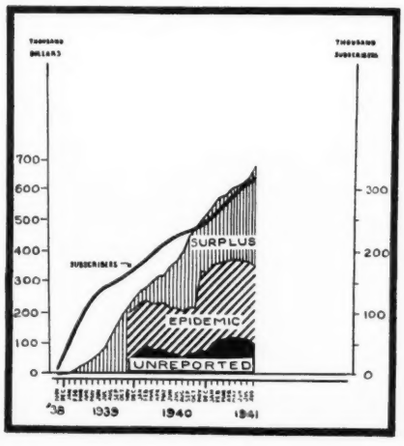
For nine years, first in Minnesota and later in Philadelphia, we have tried to devise a system of monthly reporting to directors that would be consistent and yet allow for the essential variations. With this background, the Associated Hospital Service of Philadelphia has devised a system of reporting forms that can be conveniently carried by finance committee members; this system includes a complete record of all the vital factors by months. It includes definitions of all terms used, with graphs that can easily be added to from month to month. With such information readily available, policy decisions are greatly simplified not only for the plan administrator but also for the designated officers and the board of directors.

All reporting forms in the finance committee report, as may be noted from the accompanying illustrations, are on a monthly basis. A special typewriter providing more characters per lineal inch and more lines to each page has been purchased and the forms so organized that new figures may be added each month. All of the forms, in addition to providing monthly totals of each item, include half-yearly and yearly totals and totals to date. The forms as devised provide for four years and two months' experience. This capacity may be increased, however, so that approximately six years' experience can be included in a single book enclosed as in a brief case.

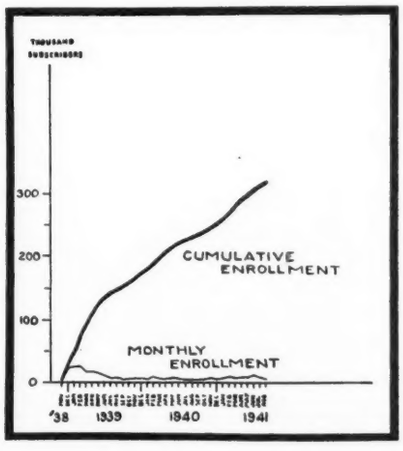
This report is ready and in the hands of the finance committee members on the fifteenth of the month following the close of business. Thus, the report for June 30

In addition to the tables, each book has a series of graphs showing in simple outline form the most significant data about the month's developments. These three show: (a) the composition of the reserve funds and (b) the net monthly enrollment and cumulative enrollment and (c) the per cent of subscriber cancellations.

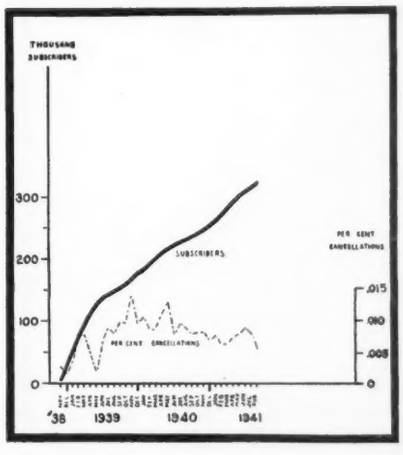
NET ENROLLMENT OF SUBSCRIBERS SHOWING CUMULATIVE RESERVES BY RESERVE TITLES
BY MONTHS



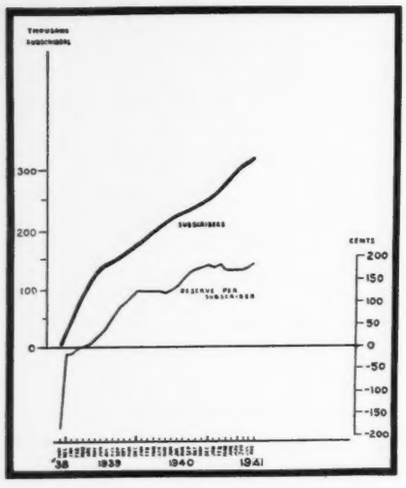
NET ENROLLMENT OF SUBSCRIBERS SHOWING CUMULATIVE ENROLLMENT
BY MONTHS



NUMBER OF SUBSCRIBERS, AND RATIO OF SUBSCRIBERS CANCELLED, TO TOTAL NET MEMBERSHIP
BY MONTHS



NUMBER OF SUBSCRIBERS AND RESERVE PER SUBSCRIBER FOR EPIDEMICS AND OTHER CONTINGENCIES (INCLUDING SURPLUS)
BY MONTHS



The column on the left applies to the number of subscribers; that on the right, to the reserve for each.

is in the hands of the finance committee on July 15.

All data have been organized into five divisions: enrollment, financial, exposure, hospitalization and operating expense. The definitions are similarly organized so that definitions for each section are separately provided.

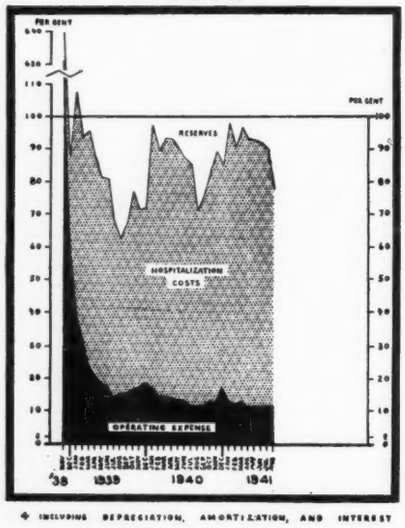
Enrollment data are included in two sections, under exposure and under enrollment. This provides for the one inconsistency that occurs in all financial or statistical reporting in Blue Cross plans. Since most plans are required by custom, and in many cases by state law, to provide a grace period, and since most plans are advised of changes in coverage at the time of group remittance, advice concerning changes often reaches the plan after the subscriber employed by the concern has left its employ or left the city. If in a particular industrial organization the number of subscribers is large and drawn from many departments, such a firm cannot notify the plan of all changes in advance of the effective date. Cut-off date information, similar to information obtained at the census taking hour in the hospital, must, therefore, be revised in later reports.

These changes include cancellations, changes in family status, additions, suspension of coverage during military service and others. The paymaster may not know that an employe has left or been discharged until pay checks are being prepared. Payment for such an employe cannot be made unless he has earnings due. If ignored, such changes would distort exposure data. Since exposure data are the measure of a plan's relative effectiveness, any tabulation of exposure data must reflect the same experience from whatever basis the analysis may be made. For many comparative purposes, however, enrollment, cancellations, the number of subscribers per contract, as reported by the enrollment department, are adequate.

New agreements (or subscribers) registered under exposure includes all agreements that have appeared on the registers of new agreements. The controls are established from these registers. Since the controls are first a control of billing, they include the items to be billed and exclude those that are not to be billed. They reflect the same cutoff dates as are used for billing. Agreements to be in the first of the month billing must be on hand by the twentieth of the preceding month and agreements to be in the fifteenth of the month billing must be on hand by the fifth of the current month. Agreements on hand on those dates will be in the registers for the next month and will then be added to the controls. Therefore, statistics on enrollment and cancellations are reported as of the billing cutoff dates, not as of the end of reporting periods.

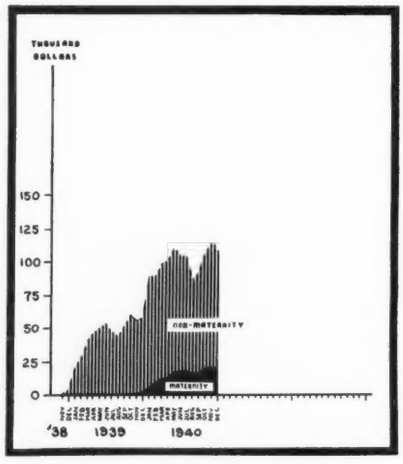
Operating expenses in Philadelphia are now down to just over 10 per cent, as is apparent from this chart.

RELATION OF OPERATING EXPENSE, HOSPITALIZATION COSTS, AND ADDITION TO RESERVES
BY MONTHS



* INCLUDING DEPRECIATION, AMORTIZATION, AND INTEREST

HOSPITAL COSTS FOR MATERNITY AND NON-MATERNITY CASES
BY MONTHS



The growing expense of maternity service as related to total hospital expense is shown clearly above.

Certain of the reports, those dealing with the detail of utilization by categories of subscribers or by cause of hospitalization, are not reported upon a current basis. This is caused by the fact that the corporation's liability for hospital care extends 120 days (at 25 per cent) beyond the first twenty-one days of full coverage. This inventory of bills not yet presented, although admission notices have been received and liability for payment assumed, cannot be reported upon in detail until the full term of the corporation's liability has passed.

Originally, all earnings reports in the Philadelphia plan were upon a cash basis. The corporation did not provide separately for the reserve for unreported and undischarged cases. The Philadelphia basis of reporting was changed to the accrual method in June 1940. Figures were then provided to every director which summarized, on an accrual basis, all financial data since the beginning of operations. All financial data in the reports that followed and all financial data since the date of the change to the accrual method have been reported upon the same basis, using the same figures for previous months.

The illustrations do not include two important forms: (a) a summary of operating expense divided between enrollment and administrative expenses and (b) the monthly ratios of patient days to subscriber months by types of contract.

Uncovering Buried Statistics

Mechanical Classification of Records

R. D. BRISBANE

Superintendent, Sutter General and Maternity Hospitals, Sacramento, Calif.

LYING buried in the clinical charts and the duplicate bills of every hospital is a wealth of material that should be used constantly for plotting the growth of departments and for steering the course of the institution's future.

In the same manner that the experienced navigator of a ship or an airplane takes into account his drift, headwinds, atmospheric conditions and every other force affecting his passage through water or air, administrators should have exact information for every department not only concerning income and expense but concerning all the various factors bearing upon the hospital as a whole.

The trend in departments toward certain procedures, for instance, must be followed carefully. "Treatments" that take much of the valuable time of general duty nurses have increased more than 100 per cent since ten years ago. These facts as brought out in mechanical classification can be used to educate the public concerning costs or necessary increases in rates. These figures, compared with purchases or sales, may be used as a check against each other or as a guide for the future in the purchase of needed apparatus and supplies.

Many hospitals have been handicapped in their classifications of admissions, diagnoses or credit information by the expense of manual methods.

In seeking about for a better system, we investigated the advantages of mechanical tabulation; the results have been so spectacular and of such value, principally in the codification of credit information, that we should like to pass on the results to other hospitals that may be having the same difficulties we had. The system may be used for any hospital no matter how large or small.

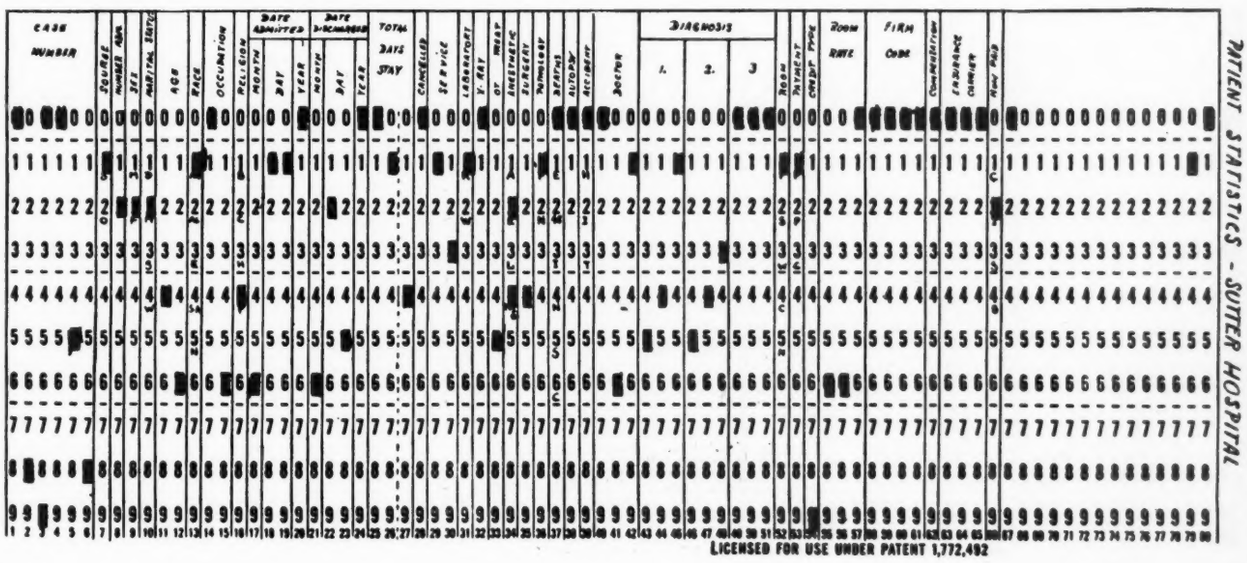
With the assistance of the representative of the tabulating machine company, a code sheet was prepared for the clinical and diagnostic information desired, patterned after that used by some of the larger hospitals. The credit portion, however, is something new in office practice for hospitals and was made up for our particular needs.

Admission and medical data are filled in each day manually by the record librarians from charts of dismissed guests. Credit information is recorded by one of the office staff from duplicate ledger sheets of guests. Columns on the code sheet synchronize with numbered columns on the punch card for convenience of the punch operator.

Each heading and column represents from 10 to 999 items, totaling nearly 2700 separate ways in which guests may be classified.

Completed code sheets are sent to the office of the tabulating company twice a year, where all the data for each guest are punched on a 3 by 8 inch card, with 14 columns to spare for future needs. The cards then are run through their sorter at the rate of 24,000 hourly, read back for accuracy and the number of guests under each classification and each item is typed out for permanent use of the hospital in formulating statistical comparisons.

The punched cards are returned to the hospital where they are kept in numerical order and may be read



at any time by a librarian familiar with the code.

The column headings on the cards are:

SEX
MARITAL STATUS
RACE
SERVICE, under which the admission was made, whether communicable, E.E.N. and T., fractures, gynecologic, medical, miscellaneous, neoplasm, newborn, obstetrical, orthopedic, pediatric, dermatologic, surgical, urologic
LABORATORY EXAMINATIONS, routine, Wassermann or other tests performed
X-RAYS, deep therapy, fluoroscopic, G.I. series, G.B. visualizations, pyleograms, radiographs, radium
ANESTHETICS, avertin, ether, local, nitrous oxide, others
SURGICAL OPERATIONS, cesarean section, casts, cystoscopies, major, major-minor, minor, reductions (open and closed), T. and A., teeth extractions
PATHOLOGY, shows the total negative pathology in operations performed during a given period (this information has been especially valuable)
DEATHS, emergency, forty-eight hour, institutional, newborn, stillborn, coroner
AUTOPSIES
TYPE OF ACCIDENTS
RELIGION
TREATMENTS, indicating the treatments given in rooms: abdominal paracentesis, bladder decompression, Connell suction, electrocardiogam, intravenous solutions, I.V. blue dye, spinal encephlagraph, thoracentesis, transfusions, serum, diathermy or physical therapy, hypodermoclysis, myringotomy, aspiration, paracentesis other than abdominal, intravenous medications, spinal puncture, T.B. tests, gas therapy: CO_2, helium and oxygen, oxygen (nasal or tent), trays: bleeding, interperitoneal, nasal, suture, tonsil, tracheotomy
SOURCE OF ADMISSION, by districts
NUMBER OF ADMISSIONS, of same guest
NUMBER OF PATIENTS BY DOCTORS
DIAGNOSES, as ours is not a teaching hospital, it was decided not to give more than three diagnoses for each admission, but room has been left on the punch card for as many more as desired if the future demands; 999 diagnoses in each of the three columns are possible
ACCOMMODATIONS, private room, two bed room, ward, children, newborn
PAYMENT, full, part-pay, charity
CREDIT TYPE, county agencies, doctors, doctors' families, federal agencies, hospitalization insurance, industrial compensation, nurses, other employes, private, public liability, state agencies
ROOM RATE
FIRM, total number of guests by firms and whether they are industrial compensation cases or their families, so that we know exactly how many of the business organizations about town are patronizing the hospital and how many they send to us
NUMBER OF GUESTS BY INSURANCE CARRIER, total number of beneficiaries sent by each insurance carrier
METHOD OF PAYMENT, cash, installment, slow, bad debt

The foregoing data give an exact check on the performance of the business and credit office that is hard to obtain from the total of the accounts receivable and bad debts. In short, all the clinical and credit information tabulated as outlined provides the busy executive a detailed study rarely obtainable in even the largest hospitals—all for the cost of 3 cents a card, plus the cost of the manual code sheets and the time required to fill them in.

From a clinical standpoint, this system gives the hospital any information desired by a doctor concerning all his cases or complications in addition to the primary diagnosis. As stated previously, nearly 24,000 cards may be sorted hourly, so that a physician may have the desired information in a few hours' time. If requested, three types of cases for four doctors may be sorted simultaneously. Other complex combinations and cross indexes may be tabulated in one operation, such as a particular type of case and the attending physician of each or a checkup on a certain staff member with a list of every diagnosis he has made, information not usually obtainable in the ordinary type of manual cross indexing.

Another exceptionally good feature of the punch card system is the automatic check on every surgeon when the pathologic examination of his patient has been negative.

The only complication in the system is unfinished histories, but as most of the data collected are for comparative and statistical purposes only a lag of three months generally will include everything desired, by which time every doctor on the staff should have finished his charts.

For guests still in the hospital at the time the cards are punched, the operator must go back and pick up all completed histories or ledger information following the last tabulation.

Maternity cases are being codified by themselves, including complications, because Sutter maintains a separate maternity hospital. Another set of cards cross-indexes x-ray examinations on each case according to doctor and the portion of anatomy examined.

Any administrator trying this system will be both pleased and surprised at the information, heretofore buried in a mass of paper, it places at his finger tips.

Granting Courtesy Privileges

IT IS so easy to grant a privilege and so difficult to recall or to qualify it that our staff finally adopted the following method:

Instead of maintaining a single courtesy staff that would be all inclusive, we set up two groups: courtesy staff and courtesy list. Appointments to the courtesy staff are made on the initiative of our medical board, which from time to time extends to men of outstanding ability in our community the unlimited privileges of the hospital. The type of men to whom this privilege is granted would not be assumed to undertake anything outside of their special field and we have never had any instance of its abuse.

The courtesy list is composed of physicians of good standing in the community who make application for appointment on forms provided for the purpose. These are considered by the medical board, references are scrutinized and at least one or more members make the acquaintance of the candidate. Appointments are confirmed when the candidate signs a statement indicating that he is familiar with the conditions and agrees to abide by them. Appointments are revokable at any time at the discretion of the medical board.

This division of courtesy men into "staff" and "list" has worked well over a period of several years.—F. STANLEY HOWE, *Orange Memorial Hospital, Orange, N. J.*

Stabilize Nursing Service

Through Accurate Personnel Records

CHARLOTTE C. DOWLER, R.N.

Director of Nurses, St. Luke's Hospital, Spokane, Wash.

THE first factor to be considered in deciding upon the kinds of personnel records to be used in any organization is that they be of such construction and form as to provide for the compilation of the facts most pertinent to the success of the particular personnel program for which they are intended. Only important information should be requested and the manner of requesting it should be unmistakably clear and concise.

Personnel records for the graduate staff nurse have often been unsatisfactory because the forms used were not suited to their purpose. This is especially true when student nurse records are used for graduate nurses. The adoption of records from one organization to another or from one department to another is not generally satisfactory unless the forms used have been carefully adapted to their new use.

The space allotted for answers is usually insufficient. Only the most important information should be called for on any personnel record and then adequate space should be allowed for a satisfactory answer.

Application Form Is Requisite

In order to promote careful selection and to aid in proper placement of employes, an application blank is generally employed. Items requested should include such information as will assist the employer in deciding whether the applicant has the necessary background, training, experience, education and physical fitness for the particular position desired. A suggested application blank appeared in the June issue, page 64. In addition to the material shown on the face of the record, the back contained space for references, postgraduate nursing courses, relative or friend to be notified in case of emergency and identifying data.

A satisfactory procedure is to have the applicant herself complete the application form. By this method the employer can observe the ability of the applicant to interpret questions, the length of time she needs for that purpose, as well as her ability to express herself in writing. Then by using the completed application form as a foundation for the personal interview, the employer avoids many unnecessary questions and may seek further information along definite lines.

It is beneficial to obtain the employe's choice of employment. Even when it is impractical to place the employe in the department of her choice immediately, it is a satisfaction to the applicant to know that her preference is to receive consideration. Also, it is of great value to the employer, when a need arises for assistance in a special department, to have at hand a list of workers who would be most interested.

For the same reasons, a knowledge of the choice of full-time, part-time or temporary service is desirable. Continual disruption of service comes from placing temporary employes in positions that call for regular staff members.

In selecting a staff nurse, the director should know the applicant's affiliation with professional organizations. Some states have strict regulations as to state registration of graduate nurses and the eligibility of the applicant for state registration is an important qualification for employment. Membership in professional organizations serves as an indication of the applicant's interest in professional affairs. The membership in the Red Cross Nursing Service is of special importance now.

Having received the information obtained in response to questions on the first page of the application blank, the director should decide whether the applicant deserves further consideration. If so, a review of the educational background and postgraduate training is important.

If an individual is selected for employment, a physical examination is generally required. To obtain some general information as to the applicant's physical fitness, however, a request should be made for information regarding illness or injury during the last three years. This information is not conclusive, but it serves as a basis for judging the applicant's ability to carry the expected work load or to call attention to health problems that deserve consideration. In all cases, a complete physical examination should follow.

Interviews Are Indispensable

Since the selection of personnel is a procedure dealing with human beings of various qualities and characteristics, the value of the personal interview cannot be overestimated. The observations the interviewer makes at first hand are of importance in completing the picture of the applicant as an individual by coordinating the impressions with the concrete facts presented on the application blank. Manner of approach, facial expressions, grooming, characteristics of speech and the type of questions asked by the applicant all portray important personal traits. The results of the interview should decrease labor turnover and reduce unsatisfactory placement of employes.

The impressions of the interviewer should be carefully compiled and recorded. There is no set form for recording the results of personal interviews but a suggested form appeared in last month's article.

A personal interview might reveal personal traits and characteristics that would pass unnoticed if the applicant were selected merely from information contained in the application form. Without the benefits of a personal interview, the selection of

The first section of this article appeared in the June issue, page 63.

SERVICE EVALUATION
FOR GRADUATE STAFF NURSE

Date ____ 19__ For Period

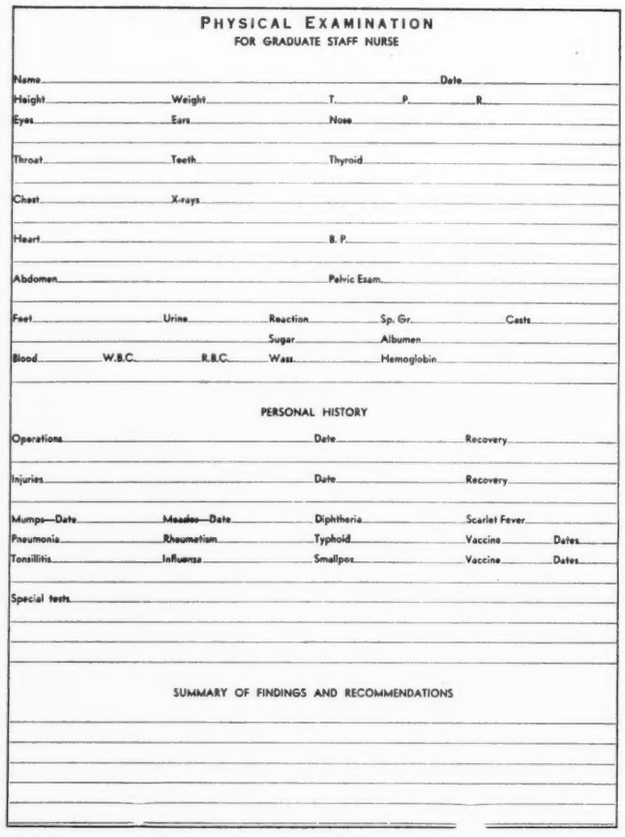
Name ____ Department ____ From ____ To ____

DIRECTIONS: Head Nurse and Supervisor score ratings in right hand columns, add totals and divide by 2 to get average rating.

	1	2	3	4	Head Nurse	Supervisor
1. Attitude	Indifferent Gloomy	Overanxious Lacks poise	Usually well poised Wholesome	Inspires confidence Stimulating		
2. Vitality	Listless Works with effort	Easily tired	Average activity	Energetic, buoyant Always busy		
3. Personal Health and Hygiene	Neglectful Objectionable to others	Appears to have poor health practice	Sound health practice	Excellent example of good health		
4. Appearance	Untidy	Does not maintain professional appearance	Usually well groomed	Immaculate Always well groomed		
5. Manner	Antagonistic Argumentative	Casual Indifferent to direction	Accepts criticism Not consistent in response	Harmonious worker Shows keen interest		
6. Sympathy and Interest	Disinterested Bored and unobservant	Personal likes influence response	Willingly helps when directed	Interested in people Anticipates patient needs		
7. Punctuality	Frequently late	Occasionally late	Seldom late for duty or reports	Always punctual		
8. Rapidity	Wastes time in purposeless effort	Slow Routine worker	Carries assignments easily	Quick and reliable		
9. Work Organization	Does not plan work	Needs direction in planning	Plans work well Completes work	Excellent organization Meets emergencies		
10. Personal Relations	Individualistic Creates resentment	Does not win cooperation	Usually tactful Gets cooperation	Very tactful Wins confidence of patients and workers		
11. Adaptability	Adjusts slowly to new assignments	Needs supervision in new situations	Carries new work easily	Able to form new plans well		
12. Technical Skill	Careless and awkward	Moderately skillful	Good technique	Excellent technique Very skillful		
13. Reporting	Does not report unfinished work, etc.	Forgets important details	Reports complete and dependable	Prompt and accurate reports		
14. Dependability	Often not reliable	Assumes unwarranted responsibility	Usually reliable	Most dependable Wins confidence of staff		
15. Care of Hospital Property	Careless and destructive	Extravagant Misuses supplies	Economical and careful	Very careful Suggests new economies		
16. Honesty	Conduct evasive and questionable	Gives impression of superficial accomplishment	Usually frank and honest	Honesty above reproach		
17. Loyalty	Fault finding Discontented	Critical of management Varies in loyalty	Usually loyal and sincere	Enthusiastic loyalty		
18. Cooperation	Creates antagonism Dictatorial attitude	Usually cooperates with other workers	Courteous attitude Wins willing cooperation	Secures unusual cooperation		
19. Judgment	Poor judgment Does not weigh values	Good judgment in normal condition	Makes reasonable decisions	Always capable of making sound decisions		
20. Initiative	Avoids responsibility Needs guidance	Capable of performing routine duties	Able to form her own plans of execution	Takes initiative in organizing work		
21. Leadership	Fails to attract confidence of others	Leads well with limitations	Good leader Attracts subordinates	Inspires others by example and interest		
22. Executive Ability	Plans only her own work	Helps plan work for others	Feels responsibility for welfare of department	Feels her responsibility to the hospital organization		
23. Social Adjustment	Does not appreciate social attitudes	Reluctantly assumes social responsibilities	Meets social responsibilities well	Tactful, gracious, and well poised		
24. Ambition	No interest in greater responsibility	Fails to take advantage of opportunities to advance	Makes use of opportunities to learn	Exceptionally eager to attain advancement		
25. Teaching Interest	No interest in teaching	Occasionally shows interest in an opportunity to teach	Frequently offers instruction to students and other workers	Enjoys opportunity to take part in ward teaching		
				TOTALS		

This report has been discussed with me: ____ Supervisor

Signed ____ Staff Nurse ____ Head Nurse



PHYSICAL EXAMINATION
FOR GRADUATE STAFF NURSE

Name ____ Date ____

Height ____ Weight ____ T. ____ P. ____ R. ____

Eyes ____ Ears ____ Nose ____

Throat ____ Teeth ____ Thyroid ____

Chest ____ X-rays ____

Heart ____ B. P. ____

Abdomen ____ Pelvic Exam ____

Feet ____ Urine ____ Reaction ____ Sp. Gr. ____ Casts ____

Sugar ____ Albumen ____

Blood ____ W.B.C. ____ R.B.C. ____ Wass. ____ Hemoglobin ____

PERSONAL HISTORY

Operations ____ Date ____ Recovery ____

Injuries ____ Date ____ Recovery ____

Mumps—Date ____ Measles—Date ____ Diphtheria ____ Scarlet Fever ____

Pneumonia ____ Rheumatism ____ Typhoid ____ Vaccine ____ Dates ____

Tonsillitis ____ Influenza ____ Smallpox ____ Vaccine ____ Dates ____

Special tests ____

SUMMARY OF FINDINGS AND RECOMMENDATIONS

the employe becomes impersonal and mechanical. It is difficult to imagine a position in which personality and personal qualifications are of greater import than in that of staff nurse.

Careful selection and placement of workers do not necessarily ensure good management. Some method must be used for measuring the employe's performance on the job and her development in service to determine possible need for additional training, better placement of promotional advantages.

The record of performance rating, or service evaluation, like all other personnel records, should be carefully organized to meet the needs of the group for which it is intended. Two features are important: (1) that the method of rating will ensure some degree of accuracy, and (2) that it will be easy to use. To avoid various interpretations of the manner of rating, the form should be so constructed as to require definite measurements. These measurements must be broad enough to differentiate between degrees of quality but not too far apart to elicit consistent answers. One of the best methods of arranging the content of the performance rating record is to state the quality to be measured and then, by graded definitions, to allow a place for checking the most suitable one. The accompanying form is suggested for this purpose. Ratings made on this form by different nurses could be used for comparative study and as a basis of in-service development, promotion or discharge.

One of the greatest benefits of service evaluations is the opportunity for work improvement and self-analysis on the part of the worker. These results can be gained only if the worker is allowed the privilege of reviewing the report and discussing it in detail with the person who has done the rating. Such action affords an opportunity for constructive criticism or praise, as the case may be, and does much to give the worker encouragement and to improve the morale of the department.

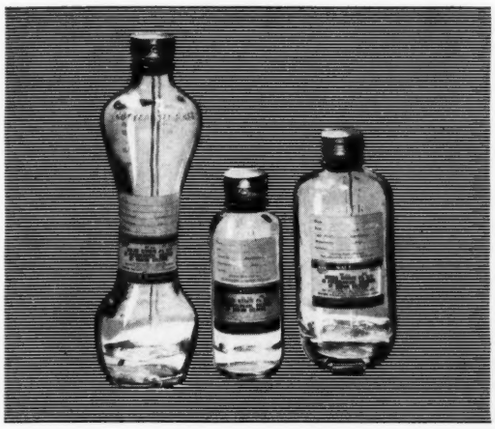
The graduate nurse's record should contain a summary of the valuable information taken from the records of service evaluation. In this way the whole record of reports on work performance of an individual nurse can be reviewed on one record. The transfer of data should be made by the director of nursing service after she has carefully examined the record of service evaluation. If she desires a conference with the staff nurse or with those who did the rating, she should record the results on the summary sheet, in addition to her remarks. Such a summary saves time and also makes possible the discard of the service evaluation records after the important information has been transferred to the summary.

The report of discontinuance of service may be attached to this record in order to supply written evidence of the reason for leaving and to serve as a source of information requested by other agencies in regard to the particular employe. This record should be the responsibility of the director of nursing service and should bear her signature.

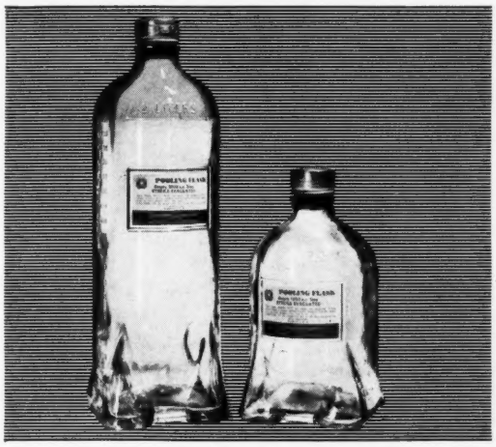
Personnel records for the health service vary with each organization and with the special requirements of the particular group. The basic requirement is a record of preliminary health examination. For the graduate staff nurse, this examination should include all routine procedures, such as blood, urine and general physical examinations, as well as any special procedures indicated. Many hospitals now require an x-ray examination of the chest of each applicant; others require x-ray examination only if special conditions are indicated. Of equal importance to the preliminary examination is periodic examination.

WHETHER YOUR HOSPITAL BEDS ARE COUNTED IN TENS OR THOUSANDS—

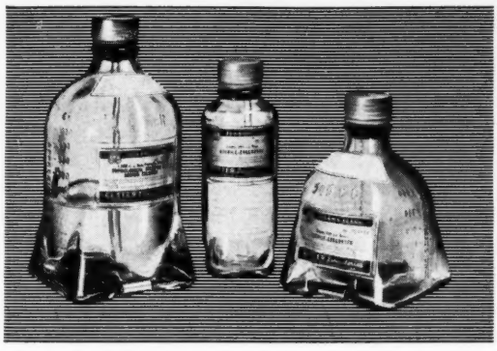
Cutter transfusion and plasma equipment is engineered to fit your needs exactly!



These three flasks will solve any donor flask problem.

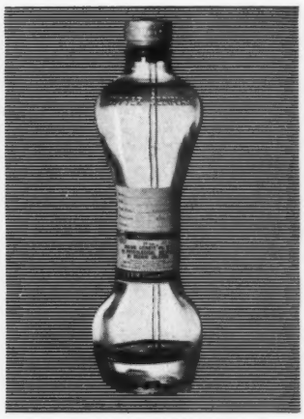


The 1000 c.c. and 2000 c.c. pooling flasks for the pooling of plasma from either Saftifuge or Sediflask.

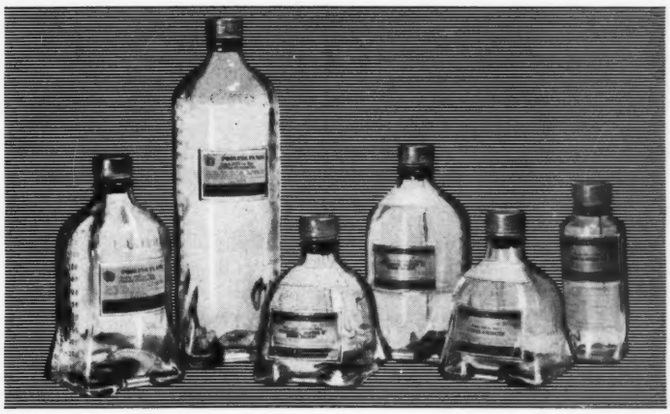


These flasks, with and without saline, solve all administration problems.

The 250 c.c. and 500 c.c. Saftifuges for the drawing of whole blood for administration or for centrifuging for plasma.



The 500 c.c. Sediflask for drawing and administration of whole blood and for greater recovery of plasma by sedimentation.



These flasks solve every problem in the hospital preparation and administration of plasma.

Ask your Cutter Saftiflask distributor or write direct for complete information and prices. We shall be glad to assist in designing just the proper set-up to suit your purpose.

CUTTER Laboratories BERKELEY • CHICAGO NEW YORK

One of America's oldest biological laboratories

Value of Uniform Accounting

JOHN P. POE

Member of the Board of Trustees, Princeton Hospital, Princeton, N. J.

THE average trustee of a hospital is not familiar with the actual technic of administering such an enterprise. There are, however, speaking purely from a point of view of figures and omitting the larger consideration of morale and service to the community, two important things he must know.

First: Is the hospital operating at a profit or at a loss? Under this broad question come three subheadings: At how great a profit or a loss is it operating? How do its operations compare with those of previous years? How do its operations compare with those of other hospitals of the same size and scope?

Second: Why? If his hospital is not operating at a profit, if it is not doing as well as it should as compared with previous years or if other comparable hospitals are doing better than his institution, he must know what causes the discrepancy before he and his board can take any proper steps to correct the situation.

Standard Systems Aid Comparison

Any good accounting system will help to show the "why" as far as the individual institution's operations are concerned, but unless that system is generally used by all hospitals and the consolidated averages made available to him for study, the trustee cannot answer the question in his mind as to whether he is up against a condition that affects only his own hospital or whether he is the victim or beneficiary of a trend.

The current report of the Committee on Accounting and Statistics of the New Jersey Hospital Association, on the system now being recommended, would seem a definite step in the right direction to assist in providing the answers to these questions. This system presents a carefully worked out and thorough plan, which, if adhered to by all hospitals in the state, will give a true picture of their operations and a fair basis for making comparisons.

Without some such common ground, how can the trustees of any hospital fairly judge the performance of their own institution? It may look good but actually be poor compared to what they could do or it may look bad and really be a good effort under adverse circumstances. Not being technicians in hospital management, trustees must rely largely on the administrator and, without a proper basis for comparison, how can they tell whether he is to be commended or censured? The operating management is entitled to a fair judgment based on actual facts and, without some good standard grounds for arriving at these facts, how can their services be properly weighed?

I can foresee, too, the time when a hospital, finding itself out of line in its performance in some respect, can go to the correlating authority and be advised of the names of hospitals which, from their figures, appear to have solved the problem involved, and which, therefore, might be able to give helpful advice to the institution needing it. Such cooperation could hardly fail to be to the general benefit and to answer the question of where to go for information.

Again, unless there is some general background for study, how can trustees formulate policies covering services to be rendered and make proper long-range financial plans for adequate service to the community? Speaking from the standpoint of commercial banking, I might explain that for many years the statements of condition and of earnings and dividends, made periodically by national banks to the comptroller of the currency, have been on a standard reporting basis from which many valuable schedules are prepared.

In addition, the American Bankers' Association gets out compilations from time to time showing various operating ratios for banks and it is of great value to be able to compare our own ratios on the sources and amounts of income and the type and amount of our expenses with these general averages. Such a procedure tells us whether we are doing better than the average or whether there are practices in our institution that are causing us to lag behind. In the latter case we are immediately warned to search for the faults and to try to correct them.

Study Service Costs

Furthermore, in common with most other banks, we have been obliged to know our costs of certain types of services more closely than was thought necessary before the depression began. The study involved has proved most useful in stopping leaks caused by providing those services at less than cost by enabling us to set up a service charge system equitably arrived at so that the smallest customer feels that his account is of value to the bank and the bank realizes that it can welcome such small business without handling it at a loss. Perhaps some day hospitals can do the same.

Until the hospitals of New Jersey and of other states, too, have worked out some similar common ground on which they can check their performance and which can be used as a basis for unit cost study of services rendered, I personally feel that they and the trustees responsible for their management are obliged to operate altogether too much by guess or by God. I might add that the Princeton Hospital has made a cost study based on the report of the United Hospital Fund, which has proved extremely valuable.

From a talk given before the 1942 New Jersey Hospital Association meeting in Atlantic City.

TODAY it is our national duty to save materials and economize in their use. Hospital supplies are particularly vital to our war effort, and must be conserved. Working together, we can effect important economies.

Adhesive is one of the more precious supplies—and it's easy to use it too lavishly. Over a period of years Curity Adhesives have been developed in "ready-made" forms that encourage economical use with no lowering of the standards of good dressings technic. By following the suggestions at the right, your staff can effect economies that will conserve precious adhesive—and save the hospital money.

The Curity representative will be glad to help you revise your instructions for ordering Curity Adhesives to take full advantage of their economy possibilities.

LEWIS MANUFACTURING CO • BAUER & BLACK
2500 South Dearborn Street, Chicago
Divisions of The Kendall Company

* *Placards shown here will constantly remind your staff to save supplies. Ask the Curity representative for the quantity you can use—or write direct.*

CURITY ADHESIVES SAVE MATERIAL, TIME, MONEY

- Shorter lengths and narrower widths can frequently be used where previously wasteful technic has been employed.
- At current prices, Curity Ready-Cut Adhesive costs less per yard than the 5 yard by 12" spools—a worth while cost advantage with no sacrifice in dressings technic.
- Curity Adhesive Ties (permanently applied retainers for dressings) save large amounts of adhesives since they don't require replacement each time a dressing is changed.

Curity
REG. U.S. PAT. OFF.

RESEARCH TO IMPROVE TECHNIC, REDUCE COSTS

Subcommittees Are Important

MAURICE R. MOORE, M.D.
Superintendent, William W. Backus Hospital, Norwich, Conn.

THE hospital board has for many years functioned in accordance with accepted tradition. Yet these groups of philanthropic men and women are no longer content to remain fixed while the world about them moves forward.

The corporation of the William W. Backus Hospital, Norwich, Conn., was effected on April 9, 1891, under the statute laws of the state of Connecticut. The number of persons composing the corporation does not at any time exceed 25, or is less than nine, any vacancy being filled by the corporation as such vacancy occurs. At each annual meeting the corporation elects from its membership by ballot a president, vice president, secretary and six other persons, who constitute the executive committee. It also appoints a treasurer who holds office for one year or until a successor is appointed. The executive committee has entire control of the hospital, meeting at least once a month and making an annual report to the corporators, but responsibility for immediate action is delegated to subcommittees.

Following its annual meeting the chairman of the executive committee appoints a number of committees, each consisting of a chairman and two other members. The types and number of such committees vary with the need of the individual institution but should include a committee on personnel, finance, public relations, nursing, maintenance of buildings and grounds, purchasing and insurance.

Each committee member is carefully chosen for his particular training in order that he will be qualified to pass judgment on matters that his committee must consider from time to time. These committees have the power to act and their action is ratified at the next regular meeting of the executive board. The superintendent is at liberty at any time to call on the chairman of any particular committee for consultation and decision.

This organization permits the superintendent to obtain decisions of importance without delay; it utilizes a great wealth of knowledge and experience that otherwise would be only partly used; it creates a public relationship that is highly desirable and equally fruitful in good will and remuneration, and it divides responsibilities so as not to call too heavily upon the time of any one member of the executive board.

The same procedure is followed with equal success at the Norwich State Hospital, which was established by the Connecticut state legislature in January 1903. Here the government of the hospital is vested in a board consisting of the governor of the state and twelve trustees to be appointed by the senate, one from each county and four from the vicinity of the institution. The board of trustees has four regular meetings a year and each board member retains his appointment for six years.

WOMEN'S SERVICE GROUPS

Fifty Groups Cooperate

From 50 different guilds some 2200 workers come weekly to Methodist Hospital, Indianapolis, to do work assigned to them. Few hospitals can improve on this record, we wager. This vast strength has been built up over ten years of effort.

Recently a sifting process has gone on and now 300 volunteers have been listed who are trained to do some specific job within the hospital. Many of these have been used in some capacity during the last six months when personnel shortages have made their presence a godsend.

Mrs. James B. Perry is the capable director of these volunteer workers; she works directly under the superintendent of nurses, Bertha Pullen.

Fifty volunteers are now on duty on the floors, answering telephones in the chart room, conducting visitors and doing other jobs assigned to them effectively and cheerfully. In six months only three volunteers have failed to report for duty and in these cases their failure to report was due to an unavoidable emergency.

Among the 300 trained women on Mrs. Perry's list of volunteers are graduates of business training courses, former registered nurses and former technicians of various types. These women are being utilized in the front office, in the laboratories and on the floors. All work, of course, is under close supervision.

The women of the 50 guilds come together once a year for election of officers. Election day comes on National Hospital Day.

Volunteers Need Supervision

To speed up expansion of volunteer service, now most urgently needed, the volunteer service department of Peter Bent Brigham Hospital, Boston, has two current projects: (1) the preparation of a handbook for volunteers, containing information on certain common routines of the institution, and (2) the making of a detailed job analysis of every volunteer job, containing an outline of the duties, necessary qualifications and type of supervision.

Joy Kimball, director of volunteer service at the hospital, has this to say about the need for supervision of volunteers' work, a significant statement:

"Volunteers need to feel that the hospital is holding them to a high standard of performance; likewise, they need some one person to whom they are responsible and to whom they can go for advice on the many unexpected problems that may arise.

"Close supervision not only catches the occasional misplacement before the volunteer becomes dissatisfied or the clinic suffers from poor service but also reveals the volunteer who is potential material for the more responsible jobs.

"Volunteers serving in clinics are under the immediate supervision of the director of volunteer service; in other jobs volunteers are assigned to some one person who is responsible for training and supervision, the director having general supervision only."

At Peter Bent Brigham 17 clinics have volunteers as clinic secretaries; other volunteers work in the outdoor department's record room and serve as chaperones in the x-ray department.

What I Expect of My Laundryman

HENRY HEDDEN, M.D.
Administrator, Methodist Hospital, Memphis, Tenn.

SOME years ago, following various changes in the personnel of the hospital, I was able to obtain the services, as chief engineer, of a man who had had several years of college and university training. He didn't profess to know anything about laundry operation but he did have the willingness, the industry and the capacity to try to learn.

The hospital is a member of, or subscriber to, a number of technical and advisory services in the laundry field. I expect my laundry manager to make full use of all the services available under this arrangement and he does so. I expect him to read and keep abreast of the advances in the field and I make it possible for him to do this by the purchase of reference books and subscriptions to trade journals.

Must Have Executive Ability

I expect my laundry manager to know much about laundry operation, much more than I know. I expect him, first of all, to produce results that are satisfactory to the administration of the hospital. This means, of course, that operating costs must be kept at a satisfactory level, but it doesn't mean necessarily that the operating budget of the laundry shall be held to an uneconomically low figure. I expect my laundry manager to hire people who can do the work and I expect him to pay them a living wage. This may sound like heresy to many persons in the laundry industry but it is the way we try to run the whole hospital. We expect enough help to be employed in the laundry so that the work can be done within a reasonable work week; incentive is offered the help to get the work done as soon as possible because when the day's work is done the employes are allowed to go home. Maybe this is heresy, too.

I expect my laundry manager to be informed on not only the practical, but also the scientific side of laundry processes. I expect him to produce frequent and reliable reports on operation. I expect him to know exactly what it costs per unit to produce given results and the only way he can know that and report it to me is to have available the necessary laundry equipment, such as easily read scales and adequate accounting assistance to produce statistics.

I hardly have the temerity to make the statement that I expect my laundry manager, through careful and economical operation of his department, to save enough money to pay off the mortgage indebtedness of the hospital, but, actually, the savings already achieved have almost been equal to our debt requirement. The amount of money necessary to retire the mortgage indebtedness on the hospital was about equal to the proved savings brought about by owning and operating our laundry.

Above all things, I expect my laundry manager to advise me of conditions in the laundry, of new processes, of the condition of equipment and of the need for new equipment. When such occasion arises from time to time, I expect him to make a study of the equipment available and to make recommendations to me regarding the purchase of new equipment and trade-in of old. If the condition of the hospital budget will at all permit, I act on my laundry manager's advice.

Within the past few years we have added to our original equipment several air operated presses, some hand operated small presses, one new and large capacity flatwork ironer, one new type of large capacity extractor and one new type of large capacity washer, as well as scales and other institutional equipment. On the advice of my laundry manager I have spent more money on large capacity modern equipment in the last two or three years than was originally spent on the entire equipment of our laundry in 1924.

Laundry Ready for Larger Load

This expansion of laundry facilities, however, was only incidental to the greatly enlarged capacity of the hospital. The result was that, instead of having a badly congested laundry unable to turn out the work in sufficient quantity when the load hit, the laundry was equipped to take care of the added load.

With all of these requirements of my laundry manager in mind, I rather hesitate to mention the fact that he is also my personnel manager and his principal title is assistant to the administrator. My board of managers has encouraged me to take an interest in various allied fields and has never insisted that I confine my energies solely to the four walls of my office or to the institution. I have tended to extend this same policy to persons in my organization and so I expect my laundry manager to take an active interest in the local, sectional and national organizations of laundry managers. His work in charge of the Methodist Hospital laundry is going to be better and his field of vision broader when he has had an opportunity to rub shoulders with others who have similar problems. He will be worth more to me and to my organization when he has had this experience.

From a paper presented before the National Association of Institutional Laundry Managers, Cleveland, Oct. 17, 1941.

Engineers' Question Box

Wasted Water

Question 9: Our city plumbing code requires that water used in the refrigerator condenser be wasted to the sewer. In other cities, I understand, hospitals use this water in a variety of ways. Our refrigerant is CO_2. Is there any real basis for this waste?—K.M., Ill.

ANSWER: If your refrigerant is CO_2, there is no real basis for wasting the condenser water. If a leak occurs and CO_2 does escape into the water system, your water will be carbonated to a certain degree. So far as anyone knows, carbonated water has not harmed anyone and it is sold at all soda fountains in a far more concentrated form than would happen in a water system.

Many cities in writing codes covering the use of water in refrigerating systems have made a blanket ruling on all refrigerants, which includes CO_2. This is done to prevent anyone from making a mistake. Wasting this water to the sewer is quite an expense. From a CO_2 machine it seems doubly wasteful.

We re-use our condenser water from CO_2 machines and it is enough to supply 90 per cent of all water to the entire hospital for all purposes exclusive of the laundry and the boilers. Our hospital has a bed capacity of 265 with a resident population of 376. We have to pay for water and the additional expense would be large if this water had to be wasted to the sewer.

I believe it would pay for a hospital using CO_2 as a refrigerant and having a code that calls for wasting condenser water to the sewer to make an appeal to the city council for the right to use it.—LELAND J. MAMER, *Engineer, Evanston Hospital, Evanston, Ill.*

Wet Dressings

Question 19: What causes wet dressings in the sterilizer? How can this annoying condition be avoided?—E.J.D., Minn.

ANSWER: There are several reasons for wet dressings:

1. If the sterilizer is of the water jacket type, it is possible that the gauge glass is stopped, giving a false reading.
2. If it is a direct steam sterilizer, the sterilizer tray may be defective and may be lying on the bottom of the sterilizer, allowing condensation to be soaked in. The tray should be ½ inch from the bottom of the sterilizer.
3. The check chamber drain may be stopped up, cutting off circulation and drain off.

To ensure dry sterilization, allow the finished run of dressings to stay in the sterilizer with the door closed for about ten minutes with steam turned on jacket; then open the door slightly and allow the dressings to dry for about one hour with steam turned on the jacket. Do not pack the sterilizer too full; keep dressings 2 inches from the door for circulation.

Check on the steam return line trap, as the chamber steam trap may be stopped up. Check to determine whether or not the main steam return valve is open; if the sterilizer is of the built-in wall type, see that the window is kept closed in cold weather or cover the sterilizer with asbestos to reduce condensation.

If vacuum is pulled on the sterilizer before and after the run is made, do not pull more than 6 or 8 inches of vacuum; open the vacuum breaker slowly after the run.—EDWARD SILVERMAN, *Assistant Engineer, Mount Sinai Hospital, Philadelphia.*

Off Season for Heating

Question 26: What maintenance of the heating system should be followed in the off-heating season?—A.B.J., Minn.

ANSWER: In the conventional type of steam heating system (vacuum return), there are four points of maintenance to be followed during the off season.

1. Shutoff Valves: All valves, manual or thermostatic, to be repacked and reseated. Test the diaphragm on air control valves.
2. Steam Traps: Usually the traps are of the thermal type. The elements and seats are to be inspected and replaced when found to be defective.
3. Thermostats: The wall type of thermostatic control may be checked if the control medium is available.
4. Vacuum Pump: The pump is the most important part of the system and should be overhauled when the bearings or the impeller are found to be worn or when the pump will not deliver the amount of vacuum specified.

In the circulating hot water system, the radiators and lines should be flushed under pressure to remove sediment and the products of corrosion.

All valves and expansion joints should be packed as in the steam system.

Air traps are to be inspected.

The system is then filled with water so that all air is expelled. The water in the system tends to keep the packing from drying and is also a potential water supply for any emergency.—GEORGE IHLENFIELD, *Chief Engineer, Cleveland City Hospital.*

New York Engineer Wins Prize

H. F. Vogel, electrical engineer of Sunmount, N. Y., is the winner of the month's $5 prize. The judges agreed on him as the winner but disagreed as to which of his articles in the June issue merited the prize. One judge preferred his answer to the question on oxygen-caused explosions while the other voted his answer to average electricity costs as best with a second vote for his answer to the question on humidity control. Thus all three of his answers draw commendation.

Why don't you, also, send in some answers? Whether you win a prize or not, you are helping other hospital engineers to meet their problems.

Here are some additional questions that have been causing difficulty:

31. Can we save money by using heat reclaimers in the discharge water from our washers in the laundry?—F.B., Ill.

32. What is the best way to remove scale from coffee urns and sterile water tanks?—J.H.D., Ky.

33. How would you test thermostatic radiator traps?—W.J.M., Ohio.

34. Our hospital has been heating with oil and we expect soon to change over to coal. Would we do better to use a stoker or a pulverizer?—R.S., Ind.

35. If we install a pulverizer, how can we avoid complaints about fly ash?—R.S., Ind.

36. What is the best way of testing lamps, ballast coils and starting switches on our fluorescent lighting fixtures?—J.B., Maine.

They rarely need attention... BUT they deserve it now!

In these days of shortages it behooves all of us to conserve that which we have. Rarely do either your automobile tires or your Sloan Flush Valves need attention, but since everything entering into their manufacture is on the critical list, they deserve it now.

Just because your Sloan Flush Valves operate so efficiently and trouble-free, year in and year out, don't take them for granted. Don't overlook their proper maintenance. Call in a master plumber today and have your Sloan Flush Valves checked over. He will make only those repairs which are necessary, and you will then have the assurance that your every Sloan Valve is again as good as new, ready for more long years of trouble-free service.

Conserve vital materials by proper maintenance.

SLOAN VALVE COMPANY
★ ★ 4300 West Lake Street, Chicago ★ ★

SLOAN FLUSH VALVES

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Housekeeping in the Obstetrical Department

During the past year special attention has been given the work of the obstetrical floor and kitchen maids in the total housekeeping program at St. Mary's Hospital, Duluth, Minn. A survey was made through diaries kept by the maids themselves and through a system of constant observation of the workers to determine the activities of these maids and the time necessary to carry out these activities on an average day.

It was found, after considerable study, that many important difficulties were present in the plan in use at the time. One floor maid carried a somewhat heavier schedule of work than the other floor maid. The maids spent a great deal of time traveling from one part of the obstetrical floor to the other. The time between 7 and 7:30 a.m. seemed to be a period of waiting since nothing was planned for the floor maids at that time. The kitchen maid marked time frequently during the day while patients were being served meals and while they were eating.

In establishing a revised plan for housekeeping in the obstetrical department these points were taken into consideration. The obstetrical floor, which has a capacity of 30 beds and which has two fairly long sections connected by a hall, was divided into separate housekeeping sections. One maid was assigned to the west section and one to the east section and each was given duties that could be carried out for the most part on her own section. The maid carrying the heavier duty load was relieved of some of her work in this new arrangement. The time schedule for the performance of duties was also rearranged to eliminate the periods during which there were no scheduled duties. The schedule of hours on duty for the three maids on the obstetrical floor were:

Maids	*Hours on Duty*
Floor maid A	7 a.m to 3:30 p.m.
Floor maid B	7 a.m. to 3:30 p.m.
Kitchen maid	6:45 a.m. to 2:15 p.m. and 4 p.m. to 6:30 p.m.

The duties of the floor maids vary somewhat because of the differences in the rooms on each section. However, their activities are mainly to care for the floors and the furniture of the patients' unit and to help care for the entire unit after the discharge of the patient. They also have charge of the cleaning of all tile and glass sections of the floor rooms and walls; the nursery is included in this group of rooms. The maids go to the laundry to get the linen and arrange it on the shelves of the linen closet. On an average day the duties of the floor maids include:

West Section

1. Dust mopping patients' rooms and halls.
2. Wet mopping patients' rooms (each room twice a week).
3. Wet mopping all accessory rooms except the kitchen.
4. Scouring lavatories: clean tiling once a week.
5. Emptying wastebaskets and dusting radiators.
6. Assisting in carbolizing units of patients who have gone home.
7. Caring for patients' flowers.
8. Caring for sunparlor floor, furniture and windows.
9. Wet mopping nursery unit.
10. Carbolizing nursery beds after discharge of babies.
11. Sorting and piling linen.

East Section

1. Dust mopping patients' rooms and halls.
2. Wet mopping patients' rooms (each room twice a week).
3. Wet mopping all accessory rooms except kitchen.
4. Emptying wastebaskets and dusting radiators.
5. Caring for shelves and cupboards in utility room and laboratory.
6. Sorting and piling linen on shelves in linen closet.
7. Assisting in the packing of nursery linen.
8. Assisting kitchen maid in carrying back noon trays.
9. Assisting nurses in carbolizing units of patients who have gone home.
10. Caring for hall between the obstetrical division and the central supply room.

The duties of the kitchen maid on an average day are summarized as follows:

1. Preparing coffee for breakfast trays.
2. Setting up, collecting and dismantling patients' diet trays.
3. Sending dishes to dishwashing room and washing certain dishes that are to remain on the obstetrical floor.
4. Assisting the floor maids in sorting and piling linen.
5. Wet mopping kitchen floor every day.
6. Caring for the cupboards and tiling in the kitchen once a week.
7. Caring for the refrigerator units daily.

The maids on this floor relieve one another for days off duty except during the times when the service is particularly heavy. At such times a relief maid is sent on a full-time basis to carry on the work of the maid off duty.

We have set up certain criteria by which to judge the effectiveness of the housekeeping program. They are:

1. Are the patients' units, accessory rooms and hospital corridors clean and are they free from unnecessary equipment?
2. Are the patients comfortable and undisturbed while housekeeping activities are being carried out?
3. Can we care for emergency housekeeping situations with a minimum of effort and with the least possible change from hospital routine?
4. Has every precaution been taken to prevent accidents and have the workers been made conscious of their part in an accident prevention program?
5. Are the workers satisfied with their jobs?

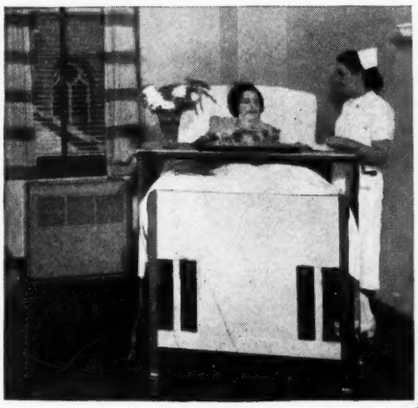
In looking forward to the housekeeping program and the activities of the workers during the next several years, we believe we will need to put additional emphasis upon such matters as the conservation of supplies and the preservation of equipment. The place of the worker in the housekeeping department will require special attention as the number of nurses in civilian hospitals becomes smaller. Like many other hospitals, we feel keenly the transfer of workers from this field to defense industries. A constant evaluation of the program and continuous supervision of the workers are, perhaps, the best guarantees we will have for the maintenance of our standards in this field.

SAVE ON SOAP!

The country's supply of fat, which is the base for the manufacture of soaps and soap products, must be conserved as far as possible, it is pointed out in a recent issue of the BULLETIN of the National Restaurant Association. Wise buying and economical use of soap products, therefore, are essential. Soap should be purchased in large quantities so that it can be kept in storage long enough to allow it to dry out. The removal of excess moisture makes the soap go much further. The drying process can be hastened by removing wrappings from soap several days before use

IDEAL LABORATORY CONDITIONS—Experiments can be carried on free from outside dirt and dust. Outdoor air, cleaned and correctly humidified, is supplied through conduits to this modern laboratory and other rooms in the new wing.

POST-MORTEMS are conducted with very latest type equipment in the post-mortem room in the new eight-story addition at St. Francis Hospital. Conditioned air is provided by the revolutionary new Carrier Conduit Weathermaster system. No chance for circulation of disease germs and objectionable odors from one room to another.



NO DRAFT — NO DUST — NO DIN. Windows are always closed and the temperature in private patients' rooms in the new wing is always the best for rapid recovery, thanks to the new air conditioning conduit system which permits individual control in each room.

The Navy "E", one of the U. S. Navy's most coveted honors, has been awarded to CARRIER *for excellence in war production.*

St. Francis Hospital, Peoria, Illinois

FIRST HOSPITAL

To Install Revolutionary New Conduit Weathermaster System of Air Conditioning

Architect: Hamilton B. Dox
Consulting Engineers: Beling Eng. Co.
General Contractor: V. Jobst & Sons
Mechanical Contractor: Crowley Bros., Inc.

Hospital history was made recently when the new eight-story addition to St. Francis Hospital in Peoria, Illinois was equipped with a new type of air conditioning system which promises to revolutionize the construction of hospital buildings.

All of the private patient rooms, clinical conference rooms, waiting rooms, solariums and offices in the new wing are served by this installation.

ENTIRELY ELIMINATES RECIRCULATION OF AIR!

The outstanding feature of this new Conduit Weathermaster system developed by Carrier is the elimination of sheet metal ducts. The new system delivers all outside air after cleaning and correctly humidifying or dehumidifying the air in a central station conditioner. This air is delivered in conduits (instead of ducts) to Weathermaster units in the various rooms. ***Thus, all recirculation of air between rooms is avoided.*** Each Weathermaster unit takes the place of a radiator and has a Winter-Summer control valve enabling the occupant of each room to enjoy heating or cooling as desired. Proper humidity is maintained at all seasons from the central plant.

Carrier Air Conditioning

CARRIER CORPORATION, Syracuse, N. Y. Desk G46
"Weather Makers to the World"

Please send information on the Carrier Conduit Weathermaster System.

Name.....
Hospital.....
Address.....
City.....

Summertime Is Ice Cream Time

S. MARGARET GILLAM and MILDRED BRAEUNIG
New York Hospital, New York City

ICE CREAM, sherbets and fruit ices are universal favorites for desserts and with the modern methods of manufacture they are no longer considered in the luxury class. The popularity of ice cream is shown by the fact that the public buys 8½ quarts of ice cream per person yearly.

With the present curtailment of labor and the rationing of sugar, institutions may find it an advantage as a substitution for other desserts to manufacture ice cream on a small scale.

Today, the counter freezer with self-contained hardening cabinets, instead of the installation of expensive equipment and a hardening room, makes it possible to produce ice cream at a low cost with the use of minimum space and at a convenient point in the institution where supervision is available. The operation of the equipment is so simple that skilled labor is not required.

Equipment Required

The production of ice cream in small departments may be carried on in an alcove or, if available, a separate room may be assigned for the ice cream plant. The equipment for the hospital requiring a production of from 50 to 100 gallons a day would consist of a 5 gallon freezer with 100 gallon hardening cabinet, a from 60 to 100 gallon dispensing cabinet, a can sterilizer, a sink and a metal storage cabinet for supplies. It is an advantage to have a walk-in refrigerator for the storage of products that are best kept at a low temperature.

Freezers of 2½, 3, 5 and 10 gallon capacity are available. The size purchased depends upon the consumption or menu plan of the institution. Quick freezing is desirable and, if a variety of flavors is made daily, production will be retarded by frequent washing of the freezer. Under these conditions more space should be planned to care for the storage of extra flavors to concentrate the production to not more than two or three during the daily freezing period.

In producing a good ice cream product in a small plant, it is advisable to purchase a pasteurized unflavored commercial basic mix. This mix is homogenized and produces an ice cream of smooth texture. This mix should be purchased according to specifications for milkfat, milk solids—not milkfat—and sugar.

The legal minimums for milkfat vary from 10 to 14 per cent by weight and may be as high as 28 per cent. A 12, 14 or 16 per cent milkfat is usually specified.

Milk solids other than milkfat are important in relation to the milkfat for correct texture and resistance to melting; the proportion should be kept between 8 and 11 per cent. If it is below 8 per cent the ice cream will be too fluffy and if it is too high the product will have a sandy texture. Sugar is important not only for sweetness but to develop the flavor. The range should be between 14 and 17 per cent of sucrose (cane sugar). Other varieties of sugar are less sweet but, under present conditions, they are used to replace a certain percentage of the cane sugar.

Cost of Manufacturing Ice Cream for April, 1942

Material		
Ice cream mix purchased	$946.25	
Flavors purchased	144.90	
		$1091.15
Labor		
Direct	$100.00	
Indirect	31.47	
		131.47
Miscellaneous Supplies		
General stores	$ 18.95	
Dry ice	6.68	
Brine (refrigeration)	.55	
		26.18
Electricity		18.75
Depreciation on equipment*		38.52
Interest on investment		11.56
Total Cost of Production		$1317.63
Number of gallons of ice cream produced		1949
Cost per gallon produced (all flavors)		$0.673

*Length of life estimated as ten years on an equipment investment cost of $4,621.97.

Use Corn Syrup

Corn syrup in liquid or in dried form aids in the blending as well as in the ultimate flavor or taste of the finished product. Production of mix under sanitary conditions, delivery at a uniformly low temperature and a low bacterial count not to exceed 50,000 per cubic centimeter are points to cover in the specification.

The whipping and freezing process, which gives ice cream its smoothness or creaminess, automatically puts in air. If a gallon of mix is whipped up to 2 gallons of ice cream, the overrun is 100 per cent. This is controlled in the freezing process and checked by weighing the finished product. Each gallon of ice cream with a 100 per cent overrun should have a net weight of not more than 4½ pounds, or 11¼ pounds for a 2½ gallon can.

For an estimate of the cost of producing ice cream, one half the cost of the mix plus 5 to 10 cents for operating expense gives the total cost per gallon. This may be compared with the cost of purchasing ice cream and the economy estimated for the institution. Sherbets and water ices, although not as popular as ice cream, give variety and are refreshing and colorful additions to fruit cocktails and fruit juice drinks when added just before serving.

They may be produced for as low as 30 cents per gallon.

Flavorings should be skillfully blended with the ice cream mix to produce a product that is delicious and eye appealing. Commercial flavorings with combinations of fruit juices, fruit pulp, diced fresh, canned or frozen fruits and nuts may be used. Colorings and concentrates may be added to advantage as well as fruit acid solutions, fruit syrups, malted milk, marshmallows, chocolate chips and flavored candies, such as peppermint or cinnamon sticks. Bisque ice creams add variety.

In addition to skillful blending, ice cream must be processed according to specifications. Careful control of the temperature of the ice cream mix before freezing is important; the ideal temperature is between 30° and 45° F. It is important to control the freezing time, which will be from eight to twenty minutes, depending upon the type of freezer and the ingredients in the mix. The ice cream should be drawn off into chilled containers, covered with parchment paper, labeled and placed in the hardening cabinet for from eighteen to twenty-four hours at a temperature of from —8° F. to —10° F. or for ten hours at —20° F. and placed in the storage cabinet for at least four or five hours at a temperature of 15° F.

Various types of containers may be used for dispensing the ice cream. For dining room service when refrigerated unit storage cabinets are available, the 2½ and 5 gallon metal containers are used. For better portion control and ease of service the ice cream may be dipped into paper soufflé cups. Some machines have attachments for measuring and dispensing the ice cream into paper cups. For the patient service in a hospital, the paper quart brick container, creased to mark the ice cream cutting portions, seems to be the most satisfactory for servicing the ice cream to the floor pantries.

A small ice cream plant, if managed carefully, will produce a variety of flavors of ice cream, sherbets and water ices at a low cost and will prove an asset to the food service.

Recipes for Making Ice Cream

Kind of Ice Cream	*Flavors Added to 2½ Gallons Unflavored Mix*		*Cost per Gallon of Made Product*
Butter pecan	Buttered pecans in syrup	2 qt.	$0.65
Caramel	Caramel creme stock	1 qt.	.60
Chocolate	Cocoa	1 lb. 4 oz.	.60
	Sugar	1 lb. 4 oz.	
	Vanilla extract	2½ oz.	
Chocolate peppermint	Oil of peppermint	....	.59
	Red coloring	....	
	Sweet chocolate chipped	2 lb.	
Coconut bisque	Coconut bisque mixture	1 qt.	.63
Coffee	Coffee fortissimo	10 oz.	.68
Lemon velvet	Lemon syrup	2½ qt.	.54
Maple walnut	Walnuts in maple syrup	1 qt.	.69
Orange pineapple	Orange pineapple mixture	1 qt.	.55
Peppermint stick	Red coloring	....	.62
	Peppermint stick candy	3 lb.	
Pineapple	Crushed pineapple	1½ qt.	.60
	Sugar	2 lb.	
	Water	1 pt.	
Strawberry	Processed strawberries	¾ qt.	.66
	Fresh or frozen strawberries	2 lb.	
Vanilla	Vanilla extract	2½ oz.	.588

Cost of Water Ices and Sherbets per Gallon

Apricot sherbet	$0.545	Orange ice	$0.379
Lemon ice	.424	Orange sherbet	.300
Lemon sherbet	.376	Raspberry ice	.512
Lime sherbet	.376	Raspberry sherbet	.518

Frozen Eggs Find Friends

NELL CLAUSEN

Dietitian, Milwaukee Children's Hospital, Milwaukee

WITH the increasing popularity of frozen fruits and vegetables many hospitals have become interested in the use of frozen eggs. Our own experience with them dates back to 1932, and we have used them since except for boiling, poaching or frying whole.

Frozen eggs are not new. The baking industry discovered their advantages some years ago and now uses several hundred million pounds annually. They come already shelled and are packed in 10 pound and 30 pound cans as whole eggs, whites and yolks. One company includes even a modified egg product containing more than the average amount of yolk normally found in eggs.

Eggs are cracked and frozen by the reliable concerns a few hours after they are laid, this operation taking place usually in plants located in rural egg production centers. The middle western grain belt is conceded to be the best "egg country" and accounts for more than 50 per cent of the egg production of the United States.

In buying frozen eggs it is well to consider whether they are "grain belt" eggs and whether or not they are "spring laid." Egg quality varies considerably throughout the year and is highest during March, April, May and early June. Food values are highest and the solid content greatest in "spring laid" eggs.

Frozen eggs should be thawed at room temperature before being used. This usually takes about twenty-four hours. If it is desired to thaw them more rapidly, the can should be placed in running water with a temperature not to exceed 80° F. Under no circumstances should eggs be thawed near a stove, radiator or in hot water. If thawed too rapidly, coagulation may take place, partially destroying the colloidal structure.

After thawing, the eggs are handled in the same manner as freshly shelled eggs. They can be used pint for pint in present recipes, approximately 10 average eggs making 1 pound of frozen eggs.

Frozen eggs save time and storage space and eliminate the messy task of breaking and separating. Furthermore, a "spring laid" grain belt frozen egg assures uniform quality throughout the year.

Save Those Vitamins!

ALBERTA M. MACFARLANE
Educational Director
National Restaurant Association

A CHECK of the list below will soon convince the dietitian of changes to be made in methods of preparing, cooking and serving foods. In many instances it will be evident that the cooking of vegetables and protein foods will require additional attention or a change in procedure.

Research workers who have made a study of food values suggest the following methods of preparation:

1. Do not peel potatoes or other root vegetables far in advance of cooking. It is unwise to peel them today for tomorrow's use. Standing in water dissolves much of the mineral and vitamin content. ☐
2. Don't chop or shred raw fruit and vegetables long in advance of serving or cooking. Any chopping or shredding of the food breaks down the cell walls and hastens the destructive loss of the vitamins. ☐
3. Do not remove an excessive amount of the outer surface from potatoes, carrots, parsnips or turnips. In many root vegetables much of the mineral and vitamin content lies in or near the skin. For this reason potatoes are best cooked in their jackets. ☐
4. Cut carrots, parsnips and other long vegetables lengthwise rather than in slices or cubes. A lesser amount of nutrients will be dissolved in the cooking water if cut in this manner. ☐
5. Never throw away water in which vegetables have been cooked. Use it in soups, gravies and sauces. This cooking water is often as rich in vitamin C as tomato juice and adds flavor to the cooking. ☐
6. Cook vegetables in as little water as possible since many vitamins are soluble in water. Either waterless or steam pressure cooking methods dissolve less of the vitamins than does boiling. ☐

Since the efficiency and health of the nation hinges on food, it is up to all of us to do our part. We know that our national efforts will have the greatest significance only when civilians as well as the men in the armed forces are getting foods rich in the necessary health-giving, energy-forming and morale-building substances. Let us pledge:

1. **To choose and buy only foods that to the best of our knowledge are in a condition to retain as much of the original vitamin and mineral content as possible.**
2. **To discard old methods of preparation and cooking for the newer ones that have been acclaimed through scientific research as the best for the preservation of essential food elements.**
3. **To plan menu items and combinations that will provide the foods essential for health.**
4. **To study and learn more about food and its great rôle in keeping America strong.**
5. **To use "enriched" breads rather than ordinary "white" bread and rolls.**
6. **To do all in our power to help spread the gospel of nutrition and to practice it.**

---

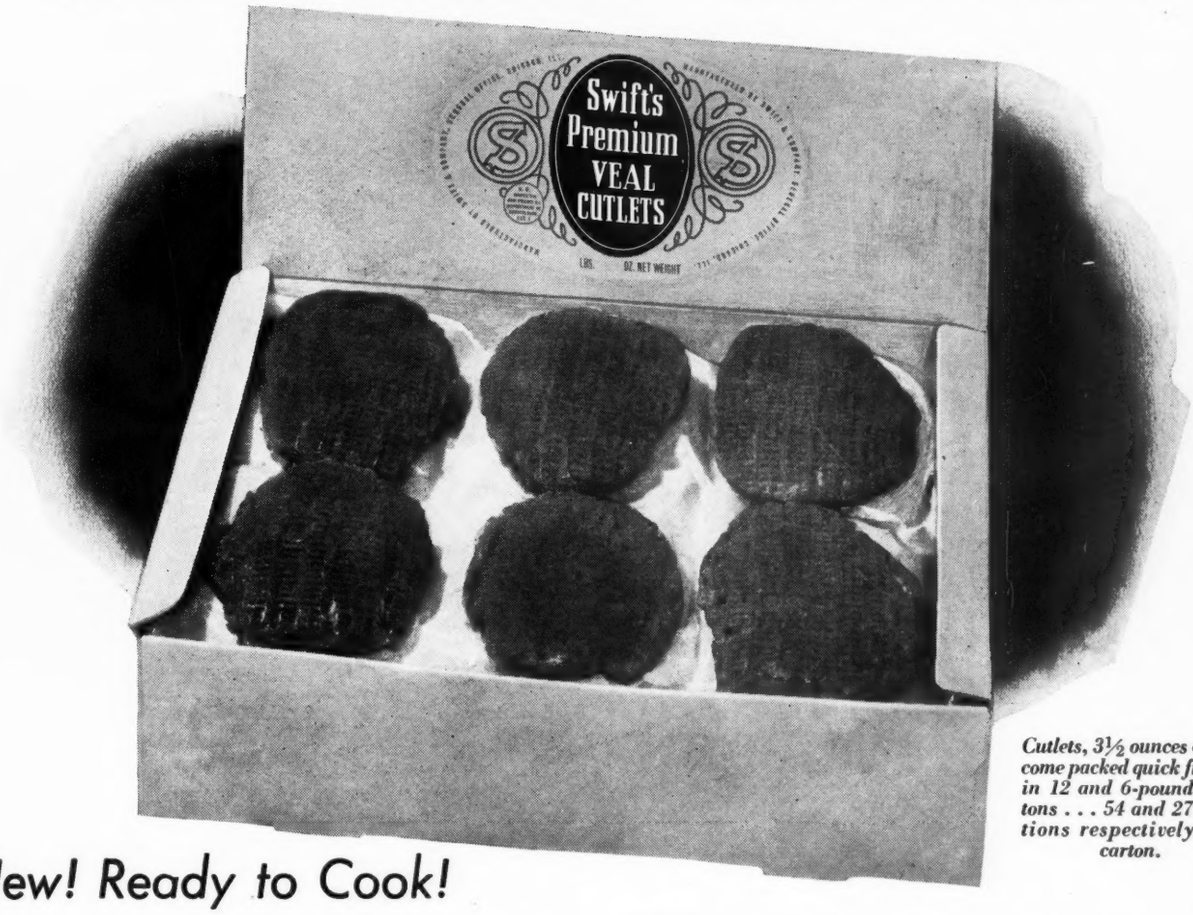
7. Raise the temperature rapidly to boiling point when cooking by boiling. Much of the vitamin content is dissolved and lost when the water is allowed gradually to come to boiling point. The use of a steam jacketed kettle gives the quickest method. Ten pounds of green beans in a kettle of 15 or 25 gallon capacity will reach the boiling point in two minutes as compared with eighteen to twenty minutes for the same quantity cooked on top of range. ☐
8. Do not use soda in cooking green vegetables, as it has a destructive effect on all vitamins. ☐
9. Retain the green coloring of vegetables by cooking in rapidly boiling water in an open kettle, timing properly. Do not allow vegetables to stand in the water after they are cooked. ☐
10. Cook vegetables in small quantities in relays and at well-timed intervals. This method gives the greatest satisfaction. ☐
11. Do not stir air into food while cooking because the oxygen of the air changes the vitamins into other substances. ☐
12. Do not sieve foods while hot. The change of vitamins into other substances is accelerated by oxygen in the presence of heat. ☐
13. Start cooking frozen foods while they are still in a frozen condition. Frozen peas, beans and spinach rapidly lose vitamin C if allowed to stand after thawing. ☐
14. Serve raw frozen fruits immediately after thawing. ☐
15. Do not fry foods rich in vitamin A, B or C. Some of the foods are beef liver, fish roe, green peppers, oysters, red salmon, potatoes, lean pork, chicken and tomatoes. ☐
16. Do not use long cooking processes, such as stewing, if shorter methods prove feasible. The former method permits greater vitamin loss. ☐
17. Don't allow food, after it has been cooked, to stand a long time, especially in the steam table. Color, flavor, vitamins and texture are destroyed by long standing and exposure to the air, especially in the presence of heat. ☐
18. Never squeeze fruit or vegetable juice much in advance of serving. Exposure to the air affects the vitamin C content. ☐
19. Keep leftovers at a minimum. Cooked foods, especially vegetables, lose much of their vitamin content standing in the icebox. ☐
20. Do not store fresh fruits and vegetables for too long a time or vitamin C is lost. ☐

YOUR PATIENTS

For satisfied smiles at mealtime . . .

YOUR STAFF

SWIFT'S PREMIUM VEAL CUTLETS!



Cutlets, 3½ ounces each, come packed quick frozen in 12 and 6-pound cartons . . . 54 and 27 portions respectively per carton.

New! Ready to Cook!

Give them a real treat—Swift's Premium Veal Cutlets! Your cooks will bring you compliments galore from both the patients and the staff. These cutlets serve up tender, juicy, delicious because they're cut only from *selected veal legs*. And for perfect freshness, they're *quick frozen*.

Swift's Premium Veal Cutlets come *ready to cook. No defrosting is necessary.* Dredge in seasoned flour (or dip in beaten egg diluted with a small amount of water, then roll in sifted, seasoned cracker crumbs). Brown in hot lard or other fat. Add a small amount of water, tomato juice or milk. Cover. Cook slowly for 15 or 20 minutes.

The uniform size of Swift's Premium Veal Cutlets—about 3½ ounces each—lets you order exact amounts, serve similar portions, figure portion costs accurately.

Buyers and dieticians for a great many institutions, both large and small, find Swift's Premium Veal Cutlets outstanding favorites on their menus. *You'll like them, too!* Order from your Swift salesman, or phone your nearest branch house. Ask, too, about the many other Swift fresh meats prepared and packaged especially for institutional use.

- Swift's Premium Veal Cutlets
- Swift's Select Veal Steaks
- Swift's Arrow "S" Veal Braisettes
- Swift's Premium Hamburger Patties
- Swift's Boned and Wrapt Beef
- Swift's Ready-Quick Beef Sandwich Steaks

HOTEL CONTRACT & INSTITUTIONAL DEPARTMENT

Swift & Company—Chicago

SUGAR RATIONING RECIPES

Lemon Meringue Pie

1 baked 9 inch pie shell
1½ cups white corn syrup
¼ cup granulated sugar
½ cup flour
½ teaspoon salt
3 eggs, separated
3 tablespoons cornstarch
2 cups boiling water
5 tablespoons lemon juice
3 tablespoons lemon rind
3 tablespoons corn syrup

Combine the 1½ cups corn syrup, sugar, flour, salt and corn starch in double boiler. Slowly add boiling water, stirring constantly. Cover and cook fifteen minutes. Beat egg yolks and gradually pour the hot mixture over them while stirring. Return to double boiler and cook five minutes longer. Just before removing from heat add lemon juice and rind. Mix well and cool. Pour into pie shell. Top with meringue made from egg whites to which the 3 tablespoons corn syrup has been added.

●

Deep Dish Apple Pie

1 cup sliced apples
2 tablespoons flour
¾ cup corn syrup
¼ teaspoon nutmeg
1 teaspoon lemon juice
2 teaspoons butter
⅛ teaspoon salt
¼ teaspoon cinnamon

Arrange apples in baking pan. Blend the remaining ingredients and pour over apples. Roll out pastry and place over apples, fold under half inch of pastry and crimp edges with floured fork. Make several gashes in top center. Bake in a hot oven (425°F.) forty minutes.

●

Sugarless Layer Cake

2¼ cups sifted cake flour
2¼ teaspoons baking powder
¼ teaspoon salt
½ cup butter or other shortening
2 teaspoons grated orange rind
1 cup corn syrup
2 eggs, unbeaten
½ cup milk
1½ teaspoons vanilla

Sift flour once, measure, add baking powder and salt and sift together three times. Cream shortening with orange rind, add syrup gradually, beating well after each addition. Add ¼ of flour and beat until smooth and well blended. (Note the new way of mixing.) Add eggs, one at a time, beating well after each addition. Add remaining flour in thirds, alternately with milk in halves, beating well after each addition. For best results, beat cake well at each stage of mixing. Add vanilla. Bake in two greased 8 inch layer pans in moderate oven (350°F.) for thirty minutes or until done.

●

Chocolate Chip Frosting

Place cake layers on baking sheet and cover tops with semi-sweet chocolate chips, using two packages. Place in moderate oven (350°F.) for six minutes or until chips are just softened. (If cake is warm, heat only three minutes.) Remove from oven and spread chocolate over bottom layer, letting it run down on sides. Arrange top layer, spreading top and sides evenly. If frosting loses its gloss, before serving place cake in moderate oven (350°F.) one or two minutes.

●

Honey Rhubarb Pie

2 eggs
2 tablespoons flour
Few grains salt
1 cup liquid honey
1 teaspoon grated orange rind
3½ cups diced rhubarb

Beat eggs, add flour, salt, honey and orange rind. Place diced rhubarb in 9 inch pastry lined pie pan. Add honey mixture and cover with pastry strips, lattice fashion. Bake in 425°F. oven forty minutes.

●

Chocolate Marshmallow Cake

½ cup shortening
¾ cup sugar
½ teaspoon salt
1 teaspoon vanilla
2 eggs
½ cup white corn syrup
2 squares chocolate (melted)
1¾ cups sifted cake flour
1 teaspoon soda
1 cup sour milk or buttermilk

Blend shortening, sugar, salt, vanilla and eggs. Add corn syrup and chocolate and beat well. Sift dry ingredients and add to first mixture alternately with milk. Bake in two 9 inch layer pans in moderate oven (350°F.) thirty to thirty-five minutes. Cover with marshmallow icing.

●

Sugarless Marshmallow Icing

Place 2 egg whites and 1 cup white corn syrup in double boiler over hot water and beat until thick and fluffy. Add 8 diced marshmallows and beat until melted. Remove from stove and beat until icing holds peaks. Melted chocolate or chocolate syrup can be dripped over top of iced cake.—CAROLINE H. AVERY. *Stouder Memorial Hospital, Troy, Ohio.*

WAR-TIME SUGGESTIONS

• The days of plenty for tea are over for the Duration; conservation of the supply on hand is a matter of real importance.

Waste of tea usually is the result of careless or improper methods of brewing. Here are a few do's and don't's suggested by the Tea Bureau, New York City, that will make your tea supply stretch over many additional cups:

Do

—Measure carefully the amount of tea and boiling water put into the pot. One level teaspoon of tea and one cup of boiling water should be used for each cup of tea desired.

—Make sure that the water is actually boiling, not just steaming, but bubbling. One of the principal causes of waste is water not brought to the boiling point, thereby leaving much of the flavor in the discarded tea leaves.

—Brew the tea for at least five minutes before pouring. If weaker brew is desired, three minutes' brewing is sufficient.

Don't

—Guess the amount either of tea or boiling water. This is the chief cause of waste.

—Be impatient. The full flavor of the tea will not be released unless it is given sufficient time to brew.

Remember, each teaspoon of tea saved means another cup another day. If these rules are followed, one pound of tea should produce approximately 200 cups and even more, if a weaker brew is preferred.

• If restrictions on sugar constitute a problem, it is suggested that a request be made to the Bureau of Home Economics for a copy of its bulletin, "Sugar in War Time." This may prove a valuable addition to the dietitian's bookshelf in these difficult times.

August Menus for the Small Hospital

Helen B. Anderson

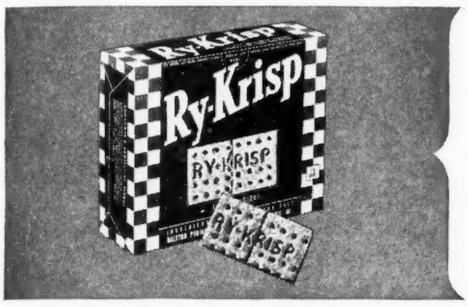
Chief Dietitian, Scripps Metabolic Clinic, La Jolla, Calif.

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Apricots	Frizzled Chipped Beef	Clam Chowder	Tongue, Baked Ham and Deviled Egg		Mixed Vegetable Salad	Watermelon
2.	Sliced Oranges	Coddled Eggs	Cream of Tomato Soup	Shepherd's Pie		Pickles, Celery Hearts, Olives	Peaches
3.	Prunes	Codfish Balls	Grapefruit and Lime Juice	Ground Round Steak	Sweet Potatoes	Molded Beet Salad	Grapes
4.	Rhubarb	Poached Eggs	Consommé	Creamed Fish	Rice	Tomato Salad	Plums
5.	Figs	Baked Hash	Cream of Corn Soup	Jellied Veal		Melon Ball Salad	Deep Apple Pie
6.	Grapefruit	French Toast	Chicken Soup	Minced Lamb in Noodle Ring		Orange and Coconut Salad	Chocolate Pudding
7.	Red Tart Plums	Eggs Poached in Milk	Vegetable Soup	Corn Custard, With or Without Ham	Potato Salad		Fruit Compote
8.	Applesauce	Bacon	Carrot Sticks	Sweetbreads in Brown Sauce	Popovers	Celery Victor	Blackberries
9.	Apricots	French Omelet	Cream of Pea Soup	Stuffed Potato With Cheese		Shellfish Salad	Peaches
10.	Sliced Oranges	Creamed Ham	Celery Hearts	Chicken and Rice		Tomato Aspic and Cream Cheese	Pears
11.	Nectarines	Coddled Eggs	Jellied Consommé	Hot Roast Beef Sandwich	Spinach	Grapefruit and Cherry Salad	Icebox Cookies
12.	Bananas	Baby Beef Liver	Apple Juice	Eggs à la Goldenrod	Corn Pone	Grated Carrot and Raisin Salad	Cantaloupe
13.	Prunes	Eggs Scrambled With Chipped Beef	Lamb Soup With Barley	Creamed Chicken	Bread Sticks	Cabbage and Peanut Salad	Plums
14.	Youngberries	Baked Eggs	Swedish Fruit Soup	Asparagus With Cheese Sauce and Bacon		Molded Pear Salad	Creamy Rice Pudding
15.	Figs	Canadian Bacon	Tomato Juice	Lamb Stew	Biscuits	Waldorf Salad	Mixed Fruit Juice Gelatin
16.	Sliced Oranges	Soft Boiled Eggs	Vegetable Soup	Cold Meat Plate	French Fried Potatoes	Mixed Fruit Salad	Sponge Cake
17.	Apricots	Scrambled Eggs	Cheese Canapés	Creamed Turkey	Baked Potatoes		Raspberries
18.	Grapefruit	Bacon	Jellied Consommé	Lamb Patties	Corn on the Cob	Cabbage and Lime Gelatine Salad	Pineapple
19.	Red Tart Plums	French Omelet	Celery Stuffed With Cheese	Clam Chowder With Potato		Mixed Vegetable Salad	Applesauce
20.	Cantaloupe	Hash	Tomato Consommé	Creamed Chipped Beef	Corn Bread	Half an Artichoke	Peaches
21.	Orange Sections	Eggs Viennese	Barley Soup	Cheese Soufflé	Lima Beans	Molded Beet Salad	Nectarines
22.	Sliced Peaches	Coddled Eggs	Broiled Grapefruit	Short Ribs of Beef	Noodles	Grated Carrot Salad	Apricots
23.	Bananas and Dates	Ham	Oxtail Soup	Fish Loaf		Egg Salad	Youngberries
24.	Figs	Shirred Eggs	Mixed Fruit Juice	Rabbit Pie With Biscuit Crust		Apple and Date Salad	Chocolate Pudding
25.	Apricots	Baby Beef Liver	Cream of Celery Soup	Corned Beef Hash With Eggs		Mixed Green Salad	Watermelon
26.	Rhubarb	Scrambled Eggs	Tomato Bisque	Minute Steaks	German Fried Potatoes	Pear Salad	Gingerbread
27.	Grapefruit	Canadian Bacon	Vegetable Soup	Chicken Sandwiches		Asparagus	Plums
28.	Fruit Compote	Soft Boiled Eggs	Creole Soup		Succotash	Tomato With Cottage Cheese	Nectarines
29.	Grapefruit	Scrambled Eggs	Vegetable Soup	Macaroni and Cheese	Asparagus	Mixed Fruit Salad	Cookies
30.	Cantaloupe	Bacon	Mixed Fruit Juice	Meat Loaf	Creamed Potatoes	Mixed Green Salad	Baked Apple
31.	Bananas	Coddled Eggs	Lima Bean Soup		Escalloped Tomatoes	Pear and Cottage Cheese Salad	Cup Cakes

Recipes will be supplied on request by The Modern Hospital, Chicago.

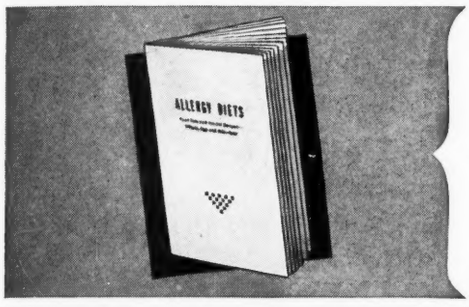
HOW RY-KRISP HELPS YOU KEEP AMERICANS IN TRIM

A word to Hospitals: *In hospitals, as elsewhere, everyone is taking on extra work — putting in extra time for National Defense. Yet the important job of planning patients' meals must go on — day after day. Won't you let us help you? Ry-Krisp diet books can save your precious time. Ry-Krisp can help you solve three common diet problems.*



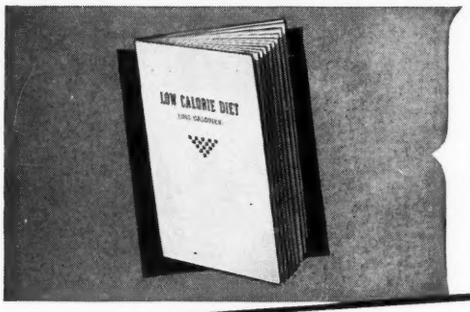
AN OUT-and-OUT WHOLE GRAIN BREAD

Made from pure whole rye, Ry-Krisp yields 7 International Units vitamin B_1 per 6.5 gram wafer, is a good source of iron, copper, phosphorus, manganese. A handy, delicious bread that has a place in the "food for freedom" program.



AIDS ALLERGY SUFFERERS

Made without wheat, milk or eggs, Ry-Krisp is a safe bread for those allergic to one or all three of those foods. To save your time, we offer handy Allergy Diets listing allowed and forbidden foods, giving tested recipes for wheat, milk and egg-free dishes.



HELPS NORMALLY OVERWEIGHT

Ry-Krisp is helpful in low-calorie diets because it has only 23 calories per wafer yet has a high hunger-satisfying value and provides bulk to aid regularity. Dietetically sound Low-Calorie Diets (1700 calories for men, 1200 for women) are available for your distribution.

Free! **Reference Book on Whole Rye**

valuable illustrated 16-page book on whole rye and its value in normal and special diets. Also Allergy Diets and Low-Calorie Diets. For professional groups only. Use coupon.

RALSTON PURINA COMPANY
951E Checkerboard Square, St. Louis, Missouri

Please send free copy "Why Rye,"_____copies Low-Calorie Diets, _____copies Allergy Diets. No cost or obligation.

*Name*_____

*Address*_____

*City*_____ *State*_____

A Safe Way to Store Plasma

MILAN NOVAK, M.D.
Associate Professor of Bacteriology and Public Health
University of Illinois College of Medicine, Chicago

MODERN warfare has placed a great deal of emphasis on the value of utility of plasma for transfusions. Today plasma is being used more and more not only by military surgeons but also by civilian surgeons who recognize its value for emergencies arising particularly from shock, hemorrhage and burns.

Several methods have been proposed for the preservation of plasma but the processing involves accompanying risks of contamination. Concentrating and drying the plasma do not necessarily kill the bacteria as they may remain viable and start to multiply when the plasma is reconstituted with distilled water. Likewise, storage of citrated plasma at low temperatures does not kill all the bacterial contamination; there are some species that will grow even at refrigerator temperatures.

Sulfonamides as Preservatives

To eliminate the problem of bacterial contamination Novak (1939) introduced the use of sulfanilamide as a preservative for stored blood and more recently has published data on the use of the sulfonamides for storage of plasma. Exhaustive laboratory studies were made to demonstrate that 0.2 per cent concentrations of the sulfonamide derivatives, preferably sodium sulfathiazole, in plasma completely controlled the problem of bacterial contamination because it actually sterilized minimally contaminated specimens of plasma.

Increasing clinical usage of this method has corroborated the laboratory findings. Hospitals and laboratories using this method of preservation find it a simple, economical and reliable process.

The bacteria used in the laboratory experiments included 114 strains commonly found as contaminants in plasma and blood. These were isolated from stored blood and plasma, from cutaneous surfaces and from the air, dust and soil found in laboratories. The organisms included cocci, various gram negative bacilli, anaerobes and spore-formers. Sulfanilamide, sodium sulfadiazine, sodium sulfathiazole and sodium sulfapyridine were the drugs investigated.

Human citrated blood plasma was placed in test tubes and various amounts of the drugs were added in concentrations ranging from 0.02 to 0.1 gm. per hundred ml. of plasma. The tubes were inoculated with a saline dilution of the organisms. One set was placed in the refrigerator and the other was kept at room temperature. A count of the bacteria present in the tubes was made at various intervals.

It was found that the drugs exhibited a marked sterilizing effect on the plasma. In most instances this was observed in three days at room temperature. A longer period of time was required for the same results to be achieved at refrigerator temperature. Therefore, keeping contaminated plasma at room temperature for several days actually accelerated the rate of action of the drug over the time it took for sterilization at refrigerator temperature. Among the 114 strains used for these experiments, only four were encountered that required 0.2 per cent of the sulfonamide derivatives to bring about sterilization of the plasma. All other strains were completely destroyed by half this concentration of the drug.

To demonstrate further the sterilizing effect of the drugs, plasma containing 0.2 per cent of the various drugs was exposed to the air for three hours and tests were made at various intervals to determine the presence or absence of bacteria. At the end of two weeks, the plasma containing the drugs and kept at room temperature was sterile but the control contained 2500 organisms in each ml. No doubt many organisms were present in the plasma, following the exposure to the air for the three hours, that were not among the 114 organisms isolated originally, yet the 0.2 per cent concentration completely sterilized the plasma at room temperature.

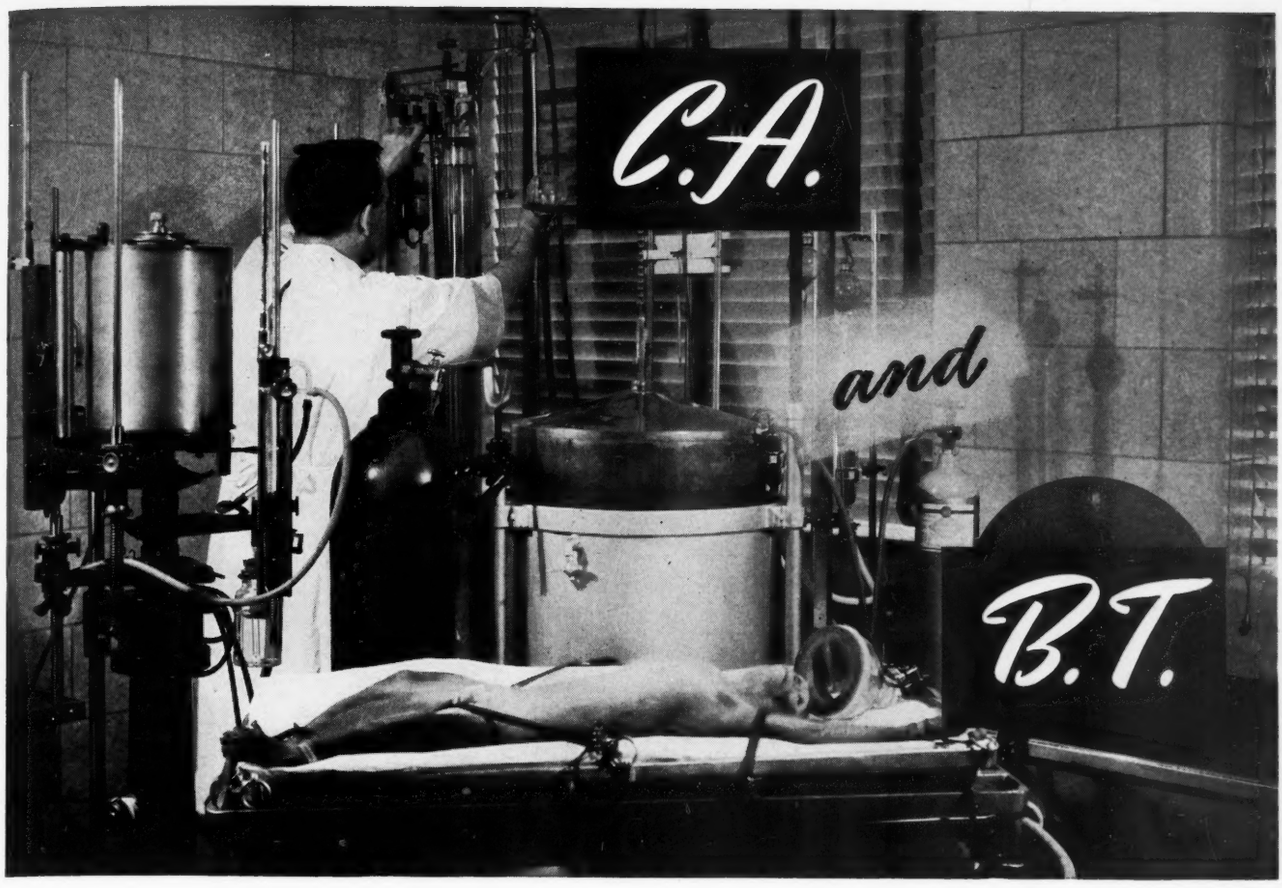
In actual use it is most convenient to draw blood from the donor directly into a solution containing the sodium citrate and the sulfonamide derivative. The antibacterial effect is thus obtained from the moment the blood is removed from the donor's vein. The solution for the flask is prepared by adding 1.5 gm. of sodium citrate and 1 gm. of sodium sulfathiazole sesquihydrate to 50 ml. of isotonic solution of sodium chloride and autoclaving in the flask into which the blood is drawn. The amount of the sulfonamide drug makes a final concentration of 0.2 per cent when 450 ml. of the blood is added.

Destroys Contaminants

Since the plasma is in the liquid state for a period of time, no matter what method is used for processing it the chances for bacterial contamination are particularly increased. Furthermore, almost all the processes, such as pooling the plasma and testing it for sterility, involve certain risks of contamination from the air and particularly from the skin surfaces. These original contaminants seldom consist of more than a few organisms and they are destroyed when a sulfonamide is present in the plasma.

Thus, when sodium sulfathiazole is used in the citrated blood it is no longer necessary for the hospitals and laboratories to discard after ten days the blood stored in this manner simply because plasma might become

(*Continued on page* 102)



WHAT does that mean? Just this—that Cyclopropane Squibb is double checked for purity... by *Chemical Analysis* and by *Biological Test.*

Chemical analysis governs the selection of raw materials, the purification methods used, as well as the purity of the finished product.

The biological test is a further assurance of quality. Rhesus monkeys are given approximately two-hour anesthesias using the carbon dioxide absorption technique. They are carefully observed for induction time and speed of recovery, circulatory and respiratory effect, muscular relaxation, amount of lacrimation and salivation and any unusual side effects. Samples of the anesthetic mixture are taken at regular intervals throughout the anesthesia for determination of percentage concentration of Cyclopropane, oxygen and carbon dioxide.

You may therefore be assured that Cyclopropane Squibb is an exceptionally pure product. Its high quality has been amply demonstrated by clinical experience in many leading hospitals. It is the brand of choice of leading anesthetists throughout the country.

Cyclopropane Squibb is available in 30 (AA); 75 (B); and 200 (D) gallon special light-weight steel cylinders . . . easier to handle . . . less costly to ship.

For literature address Anesthetic Division, 745 Fifth Avenue, New York City

E·R·SQUIBB & SONS, NEW YORK
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Shall Hospitals Provide Facilities for Endocrine Assays?

REGINALD A. SHIPLEY, M.D.
University Hospitals of Cleveland, Cleveland

A rat being injected in the animal room. Rats can be used for estrogen gonadotropic assay, but mice are preferred.

FRIEDMAN'S test can be performed in the laboratory of any hospital provided with the services of a trained pathologist. However, with the exception of Friedman's test, few hospitals have undertaken to perform endocrine assays in a routine diagnostic laboratory.

Hospitals are faced with the problem of deciding whether these assays are of sufficient value and frequently enough called for to warrant an investment in the facilities required for their execution. There is no doubting the value of hormone assays in the diagnosis of certain endocrine disorders, but it cannot be denied that the proportion of such cases encountered in hospital practice is relatively small. Furthermore, the quantitative determination of hormones calls for a laboratory setup not found in the ordinary routine diagnostic laboratory of a hospital.

In the first place, a fairly large outlay of apparatus is required and quarters for animals must be provided. Moreover, it should be emphasized that at present endocrine assays are far from being standardized procedures and, therefore, cannot be performed by an ordinary technician under the direction of a general chemist or pathologist as is now possible in laboratories performing serologic tests, blood chemistry or routine bacteriology. A reliable assay can be performed and completely interpreted at present only by a person who is particularly qualified as an endocrine chemist or physiologist.

From the fact that endocrine assay procedures are of recent development, it follows that they are as yet only crudely and incompletely perfected and that their clinical interpretation is often uncertain. It is obvious, therefore, that hormone assay work is in reality a form of scientific and clinical research and it becomes evident that a laboratory for such assays is primarily a research laboratory. Any function it may have in clinical diagnosis is largely of secondary importance. It would be poor economy to provide the elaborate facilities and highly trained personnel for an endocrine laboratory if these were devoted exclusively to the occasional assay ordered by an attending physician.

It is fair to conclude that small hospitals, for the most part, should not at present attempt to perform endocrine assays. In larger institutions in which more endocrine cases are admitted, it is desirable that some arrangement for assays be provided. Even a large hospital, however, might not feel justified in financing a department of this sort.

The scheme recently adopted at the University Hospitals of Cleveland may be cited as an example of how such an endocrine laboratory may be operated on a cooperative basis. The hospital provides laboratory space and animal quarters, while the cost of equipment, supplies and salaries is shared by the Brush Foundation affiliated with Western Reserve University. Routine assay work is performed under the joint direction of an endocrine research chemist and a clinical endocrinologist on the hospital staff. Much of the research endeavor of this laboratory will be devoted to endocrine problems related to studies being pursued by the Brush Foundation.

A setup of this kind is of advantage to the hospital, since important laboratory information on patients may be obtained; it is important to the research group because it provides not only laboratory facilities but also a convenient source of valuable clinical material.

Another recent major advance in endocrinology has been the development of potent hormonal extracts and synthetic hormonal compounds. Although these products are still of unproved value in the treatment of many of the conditions for which they are advocated, their conservative rational application in certain selected disorders promises to yield dramatic results.

Certain of the older hormonal preparations, such as epinephrine, posterior pituitary extract, thyroid substance and insulin, are well established as useful therapeutic agents. Epinephrine and posterior pituitary extract are now available in forms that prolong their rate of absorption

Photographs by B. W. Brownlow

The technician separates estrogens from androgens in the laboratory by shaking the urine extract with a solution of sodium hydroxide.

and thereby prolong their effective action. The thyroid preparation of choice is still desiccated thyroid gland. Thyroid extracts and thyroxin are more costly and of no advantage when given by mouth; the irregular absorption of thyroxin from the gastro-intestinal tract adds to its disadvantages.

Estrogens: The old types of ovarian extract and preparations of ovarian substance are now considered to be worthless. The potent natural estrogens available for clinical use consist of estradiol, estrone and estriol. Estrone and estriol are now the preferred terms for the two estrogens, theelin and theelol. Emmenin is a conjugated form of estriol. Each of the foregoing compounds is marketed by several reliable pharmaceutical houses and may be obtained, if desired, in crystalline form of high chemical purity.

Although all of these preparations are active when given by mouth, they are only from one fifth to one tenth as potent by the oral route as compared with injection. Estradiol is the most potent of the three substances and estriol, the least.

If one compares cost with relative physiologic potency, it seems evident that of the natural estrogens, estradiol is the preparation of choice. It is most efficiently utilized when given by injection in the form of the benzoate or propionate dissolved in oil.

A new inexpensive synthetic estrogen known as diethyl stilbestrol, which is very active orally, has recently been placed on the market. Its disadvantage consists of a tendency to produce nausea in a certain proportion of patients.

Corpus Luteum Hormone: An active preparation of corpus luteum hormone is available in the form of the compound progesterone. This compound is of known chemical identity and may be prepared synthetically. It is usually administered in oily solution by parenteral injection. A related compound, pregnenin-ol-one, with similar physiologic activity, may be given by mouth. It is about one fifth as potent by mouth as progesterone by injection.

Male Sex Hormone: The male hormone, testosterone, is prepared synthetically on a commercial basis and is administered in oil as the propionic ester (testosterone propionate). Methyl-testosterone, a modified form of the compound, is effective by mouth but is only about one fifth as potent as testosterone propionate by injection.

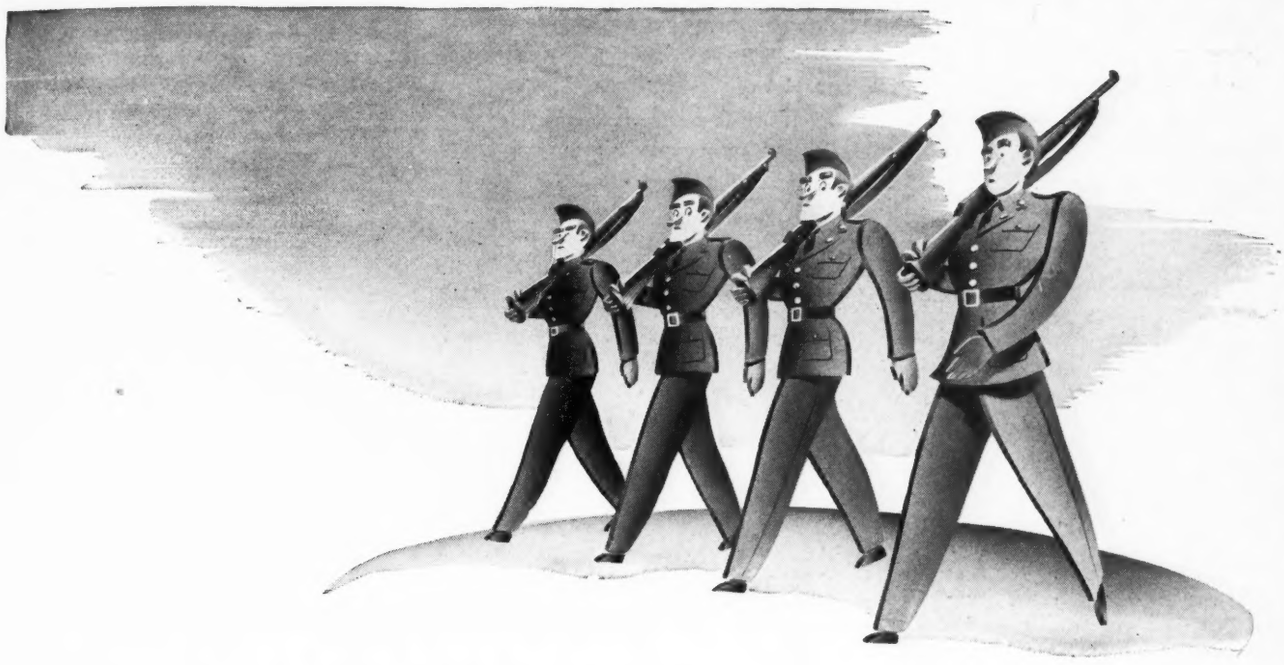
Chorionic Gonadotropin: The gonadotropic hormone of pregnancy urine is now usually known as chorionic gonadotropin. Preparations are more stable in powder form than in solution. Although this hormone is active in stimulating the ovaries of animals and has been widely used clinically, there is little evidence that it is similarly effective in the human female.

Pregnant Mare's Serum: Preparations of the gonadotropic hormone of pregnant mare's serum have recently been placed on the market. They are available in highly purified form so that the possibility of protein reactions is greatly minimized. It should be pointed out, however, that this danger cannot be entirely disregarded. Whether the claims for the superior therapeutic effect of this hormone in stimulating the human ovary will be borne out in the next few years of its trial remains to be seen.

Anterior Pituitary Extract: Various drug houses have introduced a number of anterior pituitary preparations, some of which, however, are not as yet available for general clinical use and all of which are of highly questionable value as therapeutic agents. These preparations include gonadotropic hormone, lactogenic hormone, growth hormone and thyreotropic hormone. All are relatively impure and thus may produce reactions in sensitive individuals. Moreover, they are fairly unstable in aqueous solution. All oral pituitary preparations may be considered entirely inert.

Adrenal Cortical Preparations: These consist, first, of extracts that contain a mixture of various hormones from the adrenal cortex and, second, of crystalline desoxycorticosterone, a synthetic adrenal cortical hormone. The extracts have the disadvantage of being too expensive to administer in adequate dosage over a long period of time while desoxycorticosterone, although potent in some respects, does not constitute complete replacement therapy in the treatment of adrenal cortical deficiency.

Most of the newer hormone preparations described are comparatively expensive. Their high cost combined with the poorly resolved state of our knowledge concerning their rational administration prohibits their free and indiscriminate use in an out-patient department or on the hospital ward. In an out-patient department, they can best be prescribed in a special endocrine clinic or under the direction of members of the staff who are especially interested in their use and are qualified to judge their efficacy.

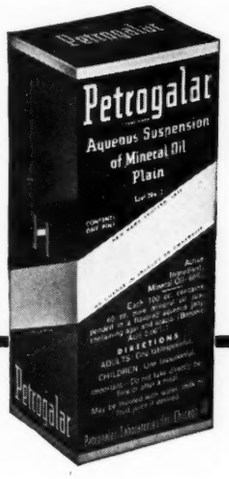


"ALL OUT OF STEP BUT JIM!"

● Intelligent Army supervision soon corrects the errors of new recruits. But in civilian life errors in personal health habits usually must be corrected by the physician.

When constipation exists, the return to regular comfortable bowel movement may often be accomplished with the aid of Petrogalar.* It helps to soften hard, dry fecal masses, rendering the stool mobile and easy to eliminate.

Consider Petrogalar for the treatment of constipation. It is palatable, economical and effective.



FOR THE TREATMENT OF CONSTIPATION

Petrogalar—

**Reg. U. S. Pat. Off. Petrogalar is an aqueous suspension of pure mineral oil each 100 cc. of which contains 65 cc. pure mineral oil suspended in an aqueous jelly containing agar and acacia.*

Petrogalar Laboratories, Inc. • 8134 McCormick Boulevard • Chicago, Illinois

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Eradicate Gonorrhea!

Because recent advances in chemotherapy have furnished the physician with a specific remedy for gonorrhea, Doctor Rice, commissioner of health of the city of New York, suggests in the February issue of *American Journal of Public Health* an expertly conducted campaign to eradicate this disease. He urges that physicians use the most efficient compound obtainable, pointing out that, in contrast to sulfanilamide, sulfathiazole produces almost no toxic effects or complications and achieves cures within ten days in 85 to 90 per cent of patients. The campaign should emphasize: (1) that the disease can be cured simply, efficiently and quickly and (2) that sources and contacts must be followed. Well-publicized facilities for the treatment of the poor patient should be provided and doctors should be furnished with information on the latest developments in therapy.—S. F. WILHELM, M.D.

● ●

The Doctor's Rôle in Nutrition

Sir John Boyd Orr, in "Trends in Nutrition," which appears in the *British Medical Journal* of January 18, calls attention to the fact that the treatment of deficiency diseases falls entirely within the sphere of the medical profession, but the prevention of these conditions lies more in the economic and political fields. Public health measures supplying milk, cod liver oil and other protective foods have, however, made progress. "The newer knowledge of nutrition . . . must be brought to bear upon the problem to enable us to get through the difficult war and postwar period."

Because the science of nutrition has advanced so rapidly, there are still many controversial beliefs. "To what extent does malnutrition exist or, in other words, to what extent could national health be improved by better feeding? What are the effects of malnutrition on national health and physique? In what respects are diets deficient and how can the deficiencies be made good from the food resources available? Lastly: What bearing has the new knowledge of nutrition upon the national effort for victory and upon schemes for postwar reconstruction?"

The methods of assessing the state of nutrition are given as physiologic, chemical, clinical and dietary surveys and feeding tests. Attention is called to the fact that the clinical training of the medical student has not as a rule fitted him to recognize the minor degrees of malnutrition. His attention has been focused upon the hospital patient in an advanced state of ill health. Some schools are now, however, focusing attention first of all upon the standards of perfect health.

Dietary surveys show that diets in common use fall short in minerals and vitamins. The marked improvement in the health and physique of young recruits on joining the Army is undoubtedly due to better feeding.

Of all the undesirable effects of malnutrition, the one of primary importance just now is the effect on working efficiency. It has been proved that improvement of the diet leads to increased output and decrease of accidents. It is likely that factories may soon be required to supply one well-planned meal per day to their workers.

Other effects of malnutrition are believed to be (1) susceptibility to infection and (2) psychological reactions, as in pellagra and lesser degrees of B_1 deficiency. It has been found that children who make poor grades at school frequently become alert and understanding when put upon diets high in protective foods.

Many experiments have been performed in the hope of determining the causative factor of dental caries and dental health. A survey of all of them, however, showed that "every child who had perfect teeth had had an abundance of milk and green vegetables regularly, without a break." The author concludes, therefore, that in the planning of the diet the most important consideration is that of the protective foods, *e.g.* milk, green vegetables, whole meal bread and potatoes. He further adds that ultimately the duties and responsibilities of the medical profession must be extended to include the prevention of disease and the promotion of health—LENNA F. COOPER.

● ●

New Ophthalmic Technics

"Recent Advances in Ophthalmology," by Dr. Algernon B. Reese, *Texas State Journal of Medicine,* November 1941, outlines briefly the enormous advances in ophthalmic technics of the last ten years. The great contributions have been made in two new operations that offer vision to patients who were previously blind. Corneal grafting is successful in 80 per cent of the cases. Detachment of the retina was previously hopeless and held out only the prospect of permanent blindness. With the new surgery available today vision is restored to more than 50 per cent of cases. Both these operations require special equipment, which all hospitals would do well to provide.

The sulfonamides are used extensively, particularly in gonorrheal ophthalmia and trachoma. Vitamins A and B deficiencies are readily noted in the eye and respond well to therapy.

The slit-lamp has become essential to ophthalmology as one of its most important diagnostic instruments. It permits microscopic study of the living eye. The gonioscope is a new instrument for the examination of the anterior chamber in glaucoma.

The new work in exophthalmos is outlined. Contact glasses that are worn under the lids is a recent sensational development. In special cases they restore vision. However, they are not practical substitutes for ordinary glasses in the average case.—S. GARTNER, M.D.

● ●

Shock Therapy in Psychoses

Electric shock treatment on 68 patients suffering from various psychoses is the basis of the discussion, "Electric Convulsion Therapy in Psychoses," by Dr. Douglas Goldman and Dr. E. A. Baber in the March issue of the *American Journal of the Medical Sciences.* Of these patients, nine recovered, 13 had a "social remission," 33 were regarded as improved and 13 as unimproved.

The authors insist that this interesting therapeutic method must still be considered experimental and not be generally applied without great caution. Patients submitted to the treatment should be observed for a long period of time afterward to determine the possibility of late complications.—E. M. BLUESTONE, M.D.

● ●

Uses for Electroencephalogram

In "Practical Clinical Uses for the Electroencephalogram," Dr. Aage Nielsen in *Harper Hospital Bulletin* for February, says that the story of the electrocardiogram is repeating itself and we are now able to measure the electrical impulses of the brain as well as the heart.

The author concludes that this apparatus is a useful agent in establishing the diagnosis of a localized brain lesion. It may, indeed, become the deciding factor in determining operative or nonoperative intervention in certain cases. This apparatus may become the most important instrument in establishing the presence or absence of tumor in patients beyond middle age with convulsions but with no localizing signs or choked disks on neurologic examination.

The usefulness of the electroencephalogram, although limited, appears to be increasing from year to year, making it mandatory for any neurologic center of repute to establish a modern department for the full exploitation of this valuable diagnostic procedure.—E. M. BLUESTONE, M.D.

NOTES AND ABSTRACTS

**Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.**

Analgesics and the War

If every combatant could have in his emergency drug kit a potent and harmless analgesic drug, much suffering and hardship could be eliminated and many minor casualty cases would be able to carry on until the close of the specific engagement. Many of these casualties could be given first aid so that excessive blood loss or infection did not result. Then, if freed of pain by a nonnarcotic drug, the soldier could go about his immediate duties.

Morphine and Its Derivatives

While our stores of opium are sufficient for a short war, none can predict how long the present conflict will last or how great a drain the casualties may make on our present supply. The combined work of Eddy and Small showed that the morphine molecule could be altered chemically in many ways to produce changed pharmacologic responses. They have produced by chemical alteration two compounds that are definitely more potent and less addicting than the original morphine. These are dehydro desoxy morphine-D and methyl-dilaudid, or metapon.

These promising compounds will only partially solve our present problem. They are less likely to produce addiction but, being derivatives of morphine, they will not solve our threatened shortage.

Analgesics are so important that if we had but a single drug to prescribe in the practice of medicine morphine would be the unanimous choice. Since the shortage of analgesics cannot be solved by morphine derivatives, the organic chemist must attempt to synthesize the morphine molecule or produce better synthetic analgesic drugs, more potent and less addicting.

Methods of Testing Analgesia

Since pain is a subjective sensation, any analgesic testing, in the final analysis, must be made on the human subject. This testing, however, cannot lend itself to many experimental compounds, hence, some animal method has been sought. In the past the usual tests have been: (1) application of a mouse-toothed forceps to the skin of a treated animal; (2) application of a tetanizing electrical current to the skin, teeth or mucous membranes of an experimental animal; (3) application of a graduated degree of pressure to the cat's tail (Eddy), and (4) use of graduated doses of radiant (heat) energy to the rat's tail to determine when the animal will flick its tail away.

The last method seems, at present, to be the one of choice. D'Amour of Denver, who introduced this test, has now applied it to more than 10,000 rats in the study of new analgesic drugs. His study on animals was the logical outgrowth of the studies of Hardy and Wolff at Cornell University on normal human subjects.

Human Testing

Applying radiant energy from a 1000 watt cylindrical bulb to the blackened forehead of the human subject, Hardy found the threshold for pain sensation to be remarkably constant. When drugs were administered to three trained, selected subjects they were able to confirm the work of Seevers (Michigan) regarding the duration and peaks of analgesia obtained with the opiate drugs. This earlier work is not as accurate as is the Hardy technic.

The accompanying table summarizes the studies of Hardy and Wolff on many of the better known analgesics. By study of their data two facts become evident, namely, that complex combinations of analgesics are not addictive in their effects and that with certain drugs, such as caffeine and ergotamine, we must attribute pain relieving effect to possible alterations in hemodynamics (as in relief of headache) rather than to changes in the pain threshold.

Reaction to Analgesics

Drug	*Dose*	*Maximum Pain Threshold Rise*
Aspirin	2 gm.	35%
Morphine	30 mgm.	100%
Codeine	60 mgm.	48%
Dilaudid	2 mgm.	110%
Metapon	5 mgm.	100%
Aspirin and codeine	.....	35%
Aspirin and caffeine	.....	38%
Paraldehyde	.....	20%
Aspirin and evipal	.....	35%
Acetanilid	.....	30%
Acetanilid and evipal	.....	30%
Acetophen	.....	35%
Aminopyrine	.....	35%
Ethyl alcohol	.....	40%
Evipal	.....	21%
Quinine	.....	0%
Caffeine	.....	0%
Ergotamine	.....	0%

Demerol

In 1926 a new local anesthetic, demerol, was studied by Langsdorff in Germany. In 1937 several publications appeared in the foreign press regarding the analgesic action of this synthetic (the ethyl ester of 1-methyl-4-phenyl piperidine-4-carbonic acid). Since then the Winthrop and Alba chemical companies have amassed considerable animal and clinical data, which may be summarized as follows:

1. Demerol may be given in repeated dosage of from 50 to 100 mgm.
2. It is somewhat irregular in its analgesic action but, when effective, it is more potent than codeine and usually less effective than morphine.
3. The duration of analgesia is from two to three hours.
4. The compound has a slight antispasmodic effect that may be of value in various "colics."
5. The main side reactions in ambulatory patients are dizziness and euphoria.
6. Tolerance to the analgesic action occurs with prolonged administration.
7. According to Himmelsbach of the U.S.P.H.S. (Lexington, Ky.), demerol is addicting to about the same degree as codeine.

While this synthetic does not fulfill the requirements of a perfect analgesic, it points the way to the synthesis of other compounds that may have more desirable properties. Since this analgesic is somewhat addicting, the question may again be asked: Will any analgesic compound ever be free of addiction liability? This can only be answered by searching for new synthetic analgesics that are not addicting.
—Carl C. Pfeiffer, M.D.

Safe Way to Store Plasma

(*Continued from page* 94)

contaminated on removal. The presence of the sulfonamide derivative will eliminate entirely this danger, since it was demonstrated that over a period of a few days the drug will actually kill bacteria that might accidentally be introduced into the material. Contaminated plasma is thus made safe for use.

Citrated plasma may be readily prepared from citrated blood at any time up to the expiration of the useful period of storage of the blood. Although the plasma may be removed by centrifuging the blood immediately after it is withdrawn from the patient, the yield is higher if the blood is allowed to stand at refrigerator temperature for at least twenty-four hours.

News in Review

Favored Position of Hospitals Shown in Revision of Health Supplies List

By EVA ADAMS CROSS

Washington Representative, The MODERN HOSPITAL

Further evidence of the favored position of hospitals in the fast changing priorities picture was given last month by the issuance of a sweeping amendment to the Health Supplies Rating Plan giving higher ratings to nearly all of the items included under the original plan and by a move to establish a section in the Services Branch of the War Production Board to cover the problems of nongovernmental hospitals.

P.R.P. Bulletin No. 84, issued on June 2, gives a rating of A-1-c to Group A items, namely, instruments, hypodermic and suture needles and x-ray tubes.

Group B items, receiving an A-2 rating, are: (1) anesthesia, oxygen and respiratory equipment and supplies; (2) medicinal chemicals (not in compounded form) considered essential for medicinal use by competent medical authority or listed in the U.S.P. or N.F., or approved by the Food and Drug Administration as a new drug; (3) non-secret biological products, antitoxins, serums, sterile ampules and intravenous solutions considered essential by competent medical authority for prevention or treatment of disease or listed in the U.S.P. or N.F. or prepared under license issued by the U. S. Public Health Service.

Additional Group B items are: (4) hypodermic syringes and clinical thermometers; (5) operating room supplies and equipment; (6) sterilizers; (7) splints and fracture equipment; (8) surgical and orthopedic appliances, including artificial limbs; (9) surgical dressings and adhesive plasters; (10) x-ray equipment and supplies, not including tubes.

Group C, given a preference rating of A-5, covers: (1) diagnostic equipment and supplies; (2) hearing aids (individual type); (3) infant incubators; (4) laboratory equipment and supplies (hospital and clinic only); (5) ophthalmic products for corrective use; (6) physical therapy equipment and supplies for institutional or professional use; (7) hospital beds, mattresses and essential bedside equipment; (8) rubber and glass hospital sundries and hospital ware; (9) sutures and ligatures.

Group D, which is rated A-8, includes: (1) atomizers for medical use only; (2) tooth brushes; (3) invalid chairs (hand operated), crutches and stretchers.

Certain items that were previously in the health supplies list are not included in the recent revision; namely: hospital carts, racks and charts, invalid walkers, ophthalmic instruments and blanket and solution warmers. The old list also included sickroom furniture, equipment and supplies but this category has now been restricted to hospital beds, mattresses and essential bedside equipment. Several new items are also included.

The outstanding characteristic of the new order, according to Milton H. Luce, administrator of the health supplies section, is a specific statement that "a rating higher than indicated by the priority pattern or the group base (rating) may be authorized to procure reasonable delivery of varying quantities of certain materials not otherwise obtainable. Authorized quantities of material are subject to material conservation orders which limit or prohibit the use of certain critical materials in the production of health supplies."

Each producer of a product under the plan is allowed one hundred per cent of the anticipated material requirements, subject to normal inventory adjustment. But the health supplies branch of W.P.B. may not authorize ratings for any material in excess of the amount named by the bureau of priorities for each quarter.

The new section for nongovernmental hospitals in the services branch of W.P.B. "will serve as a focal point for all such hospitals and will attempt to be of service to these institutions in any way possible, whether with regard to projects of expansion or in obtaining operating supplies and equipment," according to Nathaniel G. Burleigh, chief of the services branch.

"It is not intended, of course, that we shall in any way interfere with the direct procurement of equipment or apparatus from the health supply section or any other branch where the hospitals are accustomed to making direct purchases," Mr. Burleigh continues. "We expect that our relationship will be principally that of trying to assist in the maintenance of their plants and services. We hope to have this new section manned in the near future."

F. W. A. Will Examine Again All Previously Authorized Hospital Construction Projects

WASHINGTON, D. C.—Further restrictions on hospital construction were imposed last month by the War Production Board and the Federal Works Administration.

Brig. Gen. Philip B. Fleming, Federal Works Administrator, announced an overall reexamination of some 1500 construction projects previously authorized under the War Public Works program. Projects that are not indispensable to the war effort will be eliminated. Others will be "stripped" still further to reduce the use of critical materials. Priority ratings of A-1-j or above will be recommended to hasten completion of approved projects.

F.W.A. has previously cut down the use of steel, aluminum, lead, tin, copper and other critical metals. Now rubber, cork, and metal sewer and water pipe are to be reduced.

Air conditioning is limited to necessary uses such as operating rooms, not including comfort uses. Window screens cannot be metallic coated.

Essential hospitals must usually be of a temporary type, probably one story frame construction.

Interpretations by W.P.B. last month of construction order L-41 ease somewhat its application to hospitals. If construction is authorized by W.P.B. this does not count in computing the $5000 limit that a hospital can engage in without specific authorization. Also used material and equipment, if already owned by the hospital, can be taken from one building and used in another without being included in computing the $5000 construction limit. However, the estimated cost of a project shall include the costs of certain equipment physically incorporated in the building and other equipment that cannot be detached without material injury to the equipment or the building.

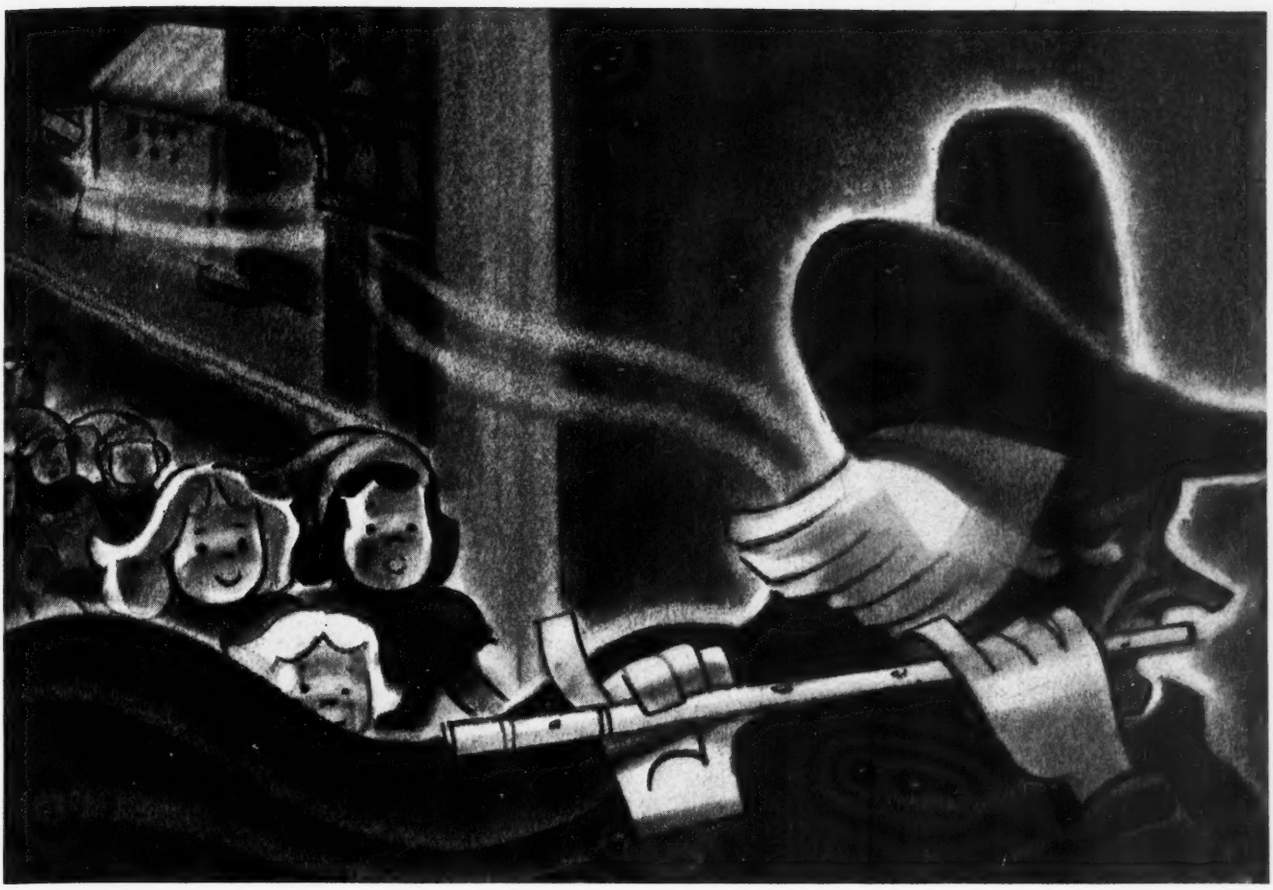
A new set of seven criteria for construction projects announced by W.P.B. are: (1) the project is essential for the war effort; (2) postponement of construction would be detrimental to the war effort; (3) it is not practical to rent or convert existing facilities for the purpose; (4) the construction will not result in duplication or unnecessary expansion of existing plants or facilities now under construction or about to be constructed; (5) all possible economies have been made in the project, resulting in deletion of all nonessential items and parts; (6) the projects have been designed of the simplest type, just sufficient to meet the minimum requirements; (7) sufficient labor, public utilities, transportation, raw materials, equipment and the like are available to build and operate the facility.

Infantile Paralysis Foundation Lists Owners of Respirators

A list of the locations and owners of the adult cabinet type of respirators has been published by the National Foundation for Infantile Paralysis, 120 Broadway, New York City.

In compiling this list the medical advisers of the foundation hope that the list will serve as a guide for those contemplating the purchase of an "iron lung" as it shows the accessibility of respirators for any given community.

"Should the purchase of a respirator be considered, we suggest that such a step be discussed with leading persons in the medical profession and a careful study be made with respect to local hospital facilities, number of respirators within transportable distance, availability of competent medical supervision, total population to be served, previous incidence of cases needing respirator treatment and whether the initial cost and upkeep warrant such a purchase," the booklet states.

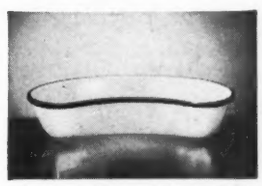


THE PIED PIPER PLAYED SO PLEASANTLY..

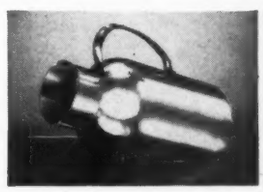
The parents of Hamelin were not aware of the importance of a little flute... But the Pied Piper played a tune that changed the entire course of the city's life.

Yes, little things may have important reactions. Vollrath Ware, for example, can stamp *your* institution as one whose *habit* is perfection. Patients and physicians alike recognize this quality. That is why leading hospitals from coast to coast insist upon Vollrath Enameled or Stainless Steel Ware . . . Since 1874—sixty-eight years ago—Vollrath has steadfastly maintained its well-deserved leadership. Today, as always, Vollrath Hospital Ware is *designed* for beauty and utility and is *built* for long life . . . We urge you to investigate!

Vollrath NuSteel Liquid Cleaner



Porcelain Enameled Pus Basin



Porcelain Enameled Male Urinal

The Vollrath Co.

Genuine Vollrath Ware Bears This Label

VOLLRATH SINCE 1874

ESTABLISHED 1874

SHEBOYGAN • WISCONSIN

War Damage Insurance at Low Rates Offered to Hospitals on Both Coasts

WASHINGTON, D. C. — Hospitals, especially those in the coastal areas, are offered war damage insurance at low rates through cooperation of the federal War Damage Corporation and the established fire insurance companies. The rate for fire-resistive hospitals with 50 per cent coinsurance is 10 cents per $100 per year and for other types of hospitals, 15 cents per $100. Premiums are reduced if higher coinsurance is carried.

The insurance protects against direct physical loss of or damage to the property described in the application which may result from enemy attack, including any action taken by the military, naval or air forces of the United States in resisting attack. Damage by fire resulting from such an attack is war damage, not regular fire damage.

The policy does not cover burglary, robbery, theft, larceny, pillage or looting during blackout or confiscation, nationalization, commandeering, capture, seizure, use and occupancy and consequential damage. Currency, securities and similar items are not covered.

The free war damage insurance provided by the government ended on July 1.

Under the new program policies will be written in the United States, Alaska, Hawaii, Virgin Islands, Puerto Rico and the Canal Zone. Hospitals wishing protection should contact their local fire insurance agents or brokers.

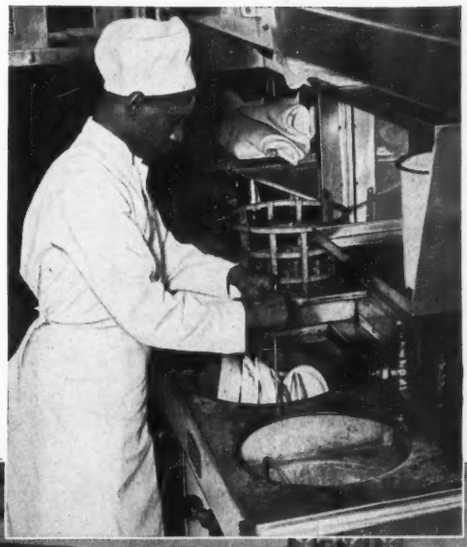
Federal Credit Restrictions Don't Apply

WASHINGTON, D. C.—To hospitals that have wondered whether the new federal credit restrictions apply to the bills they owe to hospital supply houses and others and to the bills that patients owe to hospitals, the answer is "No." The law is written to apply only to certain specified types of sales, such as household appliances, radios and similar items. The federal government, however, is generally putting pressure on all types of business to tighten up on credit and, therefore, apparently has not objected to the action of department stores and others in using this law as a lever to get accounts paid. The law, however, does not require this.

Meriden Concludes Campaign

Meriden Hospital's $500,000 building campaign, launched shortly after Pearl Harbor, has been successfully concluded at Meriden, Conn. Albert W. Savage, director of the hospital, was general chairman and Will, Folsom and Smith, Inc., conducted the drive.

KEEGO helps 'em sparkle on the Empire State Express



• Thanks in large part to Wyandotte Keego, glasses, china and silverware are kept immaculately clean on this crack New York Central train.

• Keego washes stains from dishes and glassware without laborious dipping or hand scouring, makes hand toweling unnecessary and also keeps the dishwashing machine free from lime-scale deposits.

• Why? Calcium and magnesium salts in water are largely responsible for stains on dishes, films on glassware and deposits of scale inside dishwashing machines, and these troubles can be reduced to a minimum by using Keego.

• Ask your Wyandotte Representative to tell you about the other special Wyandotte Dishwashing Products for local dishwashing problems. Wyandotte H. D. C., for example, is recommended for washing dishes by hand — Wyandotte Steri-Chlor, used in solution, for germicidal and deodorizing purposes. There's no obligation and he can probably help you to faster and more economical dishwashing.

Wyandotte
PRODUCTS
SERVICE REPRESENTATIVES IN 88 CITIES

THE J. B. FORD SALES COMPANY • WYANDOTTE, MICHIGAN

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Army

Harry Brown, Northwestern Hospital, Minneapolis.
Madison B. Brown, M.D., Roosevelt Hospital, New York City.
Lawrence R. Burt, M.D., Touro Infirmary, New Orleans.
J. R. Colburn, M.D., Alameda County Institutions, Oakland, Calif.
John C. Crimen, Southwestern General Hospital, Austin, Tex.
E. L. Demuth, M.D., Montefiore Hospital, New York City.
Edgar M. Dunstan, M.D., Parkland Hospital, Dallas, Tex.
James R. Felts Jr., Cabarrus County Hospital, Concord, N. C.
M. Herbert Fineberg, M.D., Beth Israel Hospital, Boston.
Lewis B. Gallison, M.D., Jewish Hospital of Brooklyn, Brooklyn.
T. Steward Hamilton, M.D., Massachusetts General Hospital, Boston.
George M. Hilliard, M.D., Baylor Hospital, Dallas, Tex.
W. W. Humphreys, Roper Hospital, Charleston, S. C.
Jack Latcham, Colorado General Hospital, Denver.
W. W. Lowrance, Cherokee County Hospital, Gaffney, S. C.
Rollo J. Masselink, M.D., Neurological Institute, New York City.
Paul D. Mossman, U. S. Marine Hospital, Cleveland.
Wilbur C. McLin, University of Iowa Hospitals, Iowa City.
H. A. Newell, Maria Parham Hospital, Henderson, N. C.
Robert C. Nye, M.D., Jefferson Medical College Hospital, Philadelphia.
A. Harrell Pope, Harnett County Hospital, Dunn, N. C.
Robert M. Schnitzer, Orange Memorial Hospital, Orange, N. J.
E. T. Thompson, M.D., Mount Sinai Hospital, Milwaukee.
William T. S. Thorndike, M.D., Massachusetts General Hospital, Boston.
John Van Metre, Hospital of the Protestant Episcopal Church, Philadelphia.
R. C. Warren, Baptist Hospital, Little Rock, Ark.
Herman Zaagman, Butterworth Hospital, Grand Rapids, Mich.

U. S. Navy

Daniel M. Brown, R.N., Shasta Dam Hospital, Shasta Dam, Calif.
Arthur G. Burns, St. Luke's Hospital, New York City.
John E. Morgan, M.D., St. Luke's Hospital, San Francisco.
Raymond M. Price, Sweetwater Hospital, Sweetwater, Tenn.

Royal Canadian Air Force

A. J. Chopin, St. Mary's Hospital, Montreal.

Royal Canadian Army Medical Corps

Anne Foster, Western King's Memorial Hospital, Berwick, N. S.
Pauline Graham, New Waterford General Hospital, New Waterford, N. S.
Kathleen B. Harvey, Soldiers' Memorial Hospital, Middleton, N. S.
B. S. Johnston, Montreal General Hospital, Montreal.
J. C. Mackenzie, M.D., Montreal General Hospital, Montreal.
R. T. Washburn, University Hospital, Edmonton, Alta.
G. S. Williams, Children's Hospital, Winnipeg.

Royal Canadian Naval Volunteer Reserve

J. E. de Belle, Children's Memorial Hospital, Montreal.

Military Service (Branch Unknown)

H. B. Webb, Waynesboro Community Hospital, Waynesboro, Va.

St. Louis Plan Buys War Bonds

Group Hospital Service, St. Louis, has purchased the limit in war bonds, Series G and F. Investments in U. S. securities amount to $534,917. Ten affiliated hospitals have been added to this Blue Cross plan during the year with more than 250,000 members enrolled.

A.H.A. Trustees Approve Philadelphia Statement on Social Security Plan

The trustees of the American Hospital Association have approved the statement on the Social Security Board proposals prepared by the Commission on Hospital Service Plans and adopted by the convention of the plans at its meeting in Philadelphia. The trustees also considered a statement prepared by a joint committee of the A.H.A. and the American Public Welfare Association.

This makes a total of four statements on the proposals that have been considered by the trustees, since two somewhat conflicting statements were adopted at the midwinter meetings last February.

In addition, the National Catholic Welfare Conference recently adopted a statement on the proposals, the general effect being an endorsement with modifications.

Apparently any hospital administrator will soon be able to find an "official" statement that supports his point of view on the proposals, whatever that may be.

The Commission on Hospital Service Plans also urged contiguous plans to get together now for reciprocal relations while work goes forward on a nationwide plan of reciprocity. Plans were also urged to waive the waiting period on pay roll deduction groups if a high percentage of enrollment is obtained and to give further study to the problem of enrolling individuals who are not eligible for group enrollment.

Results of a recent study of the enrollment of federal employes with a group collector plan of payment, reported to the commission, indicate that this plan is being used quite frequently when pay roll deduction is prohibited.

Surgical Supplies Reach China

Safe arrival in the Orient of 77 cases of medical and surgical supplies valued in excess of $20,000 has been reported at headquarters of the Medical and Surgical Relief Committee of America. The supplies were donated to the China convoy sent abroad last November by the Friends' ambulance unit. Dr. Robert B. McClure, commandant of the convoy, appealed for additional supplies, particularly microscopes.

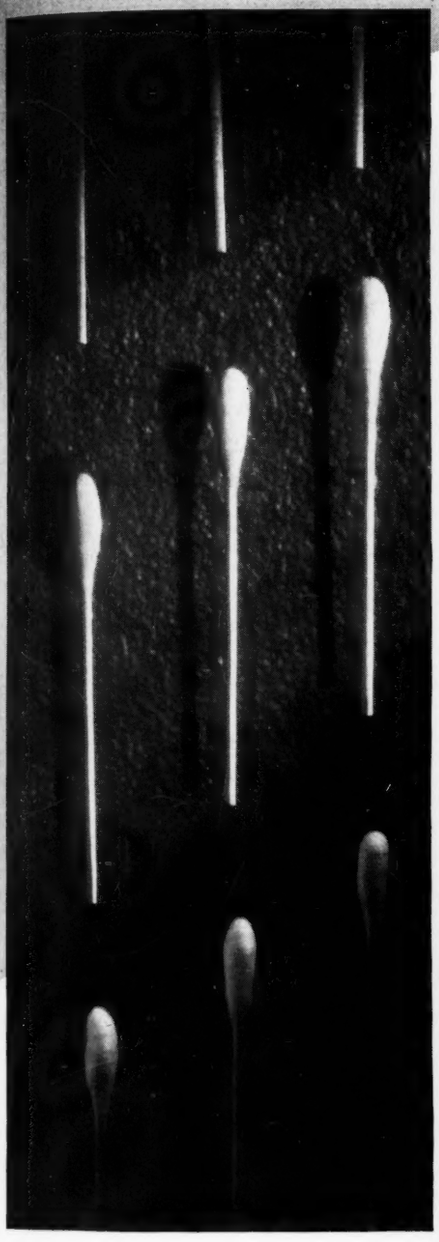
Prepared for Evacuation

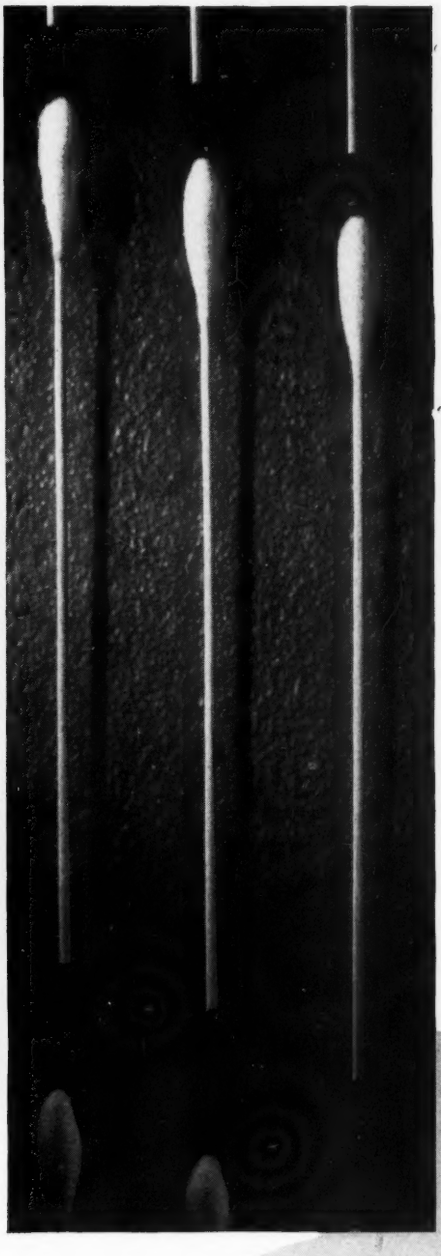
Dr. George Baehr, chief medical officer of O.C.D., reveals that preparations have been made on the West Coast and on some parts of the East Coast to remove maternity cases, children and the chronically sick from coastal hospitals to emergency base hospitals in the interior to make room for possible air-raid casualties.

Glasco

Machine-Wound Cotton-Tipped

APPLICATORS AND SWABS





A real saving in expense to the hospital because:

1. Saving in labor in wrapping applicators.
2. Machine-wound applicators are uniformly wrapped.
3. No danger of contamination through handling of the cotton in wrapping.
4. A safe and reliable instrument to use.
5. Eliminates the danger of the cotton slipping off the end of the stick.
6. Assures technicians of the cleanliness of the applicators before using.
7. Affords hospitals a most convenient method of distributing applicators throughout the hospital.
8. ECONOMICAL.

The short stick machine cottoned swab is a splendid companion item to the applicator. These soft swabs are ideal for use in the nursery as well as for a hundred other uses.

Produced by the makers of
VITAX STRAIN-FREE GLASSWARE

Consult your Glasco catalog and prescribe Glasco on all of your hospital glassware specifications. Order from your supply house. ■

GLASCO PRODUCTS

GLASCO PRODUCTS CO.

111 North Canal Street • Chicago, Illinois

Reference List of Official Orders

(Issued between May 15 and June 15)

WASHINGTON, D. C.—Many War Production Board orders of importance to hospitals were issued during the past month. For ready reference by administrators and purchasing agents they are tabulated alphabetically as follows:

Agar.—Amendment 1, issued June 13, to Order M-96 broadens the definition to include wet as well as dry forms in order to prevent the diversion of agar to nondefense purposes.

Arsenic.—General Preference Order M-152, issued May 27, places arsenic under allocation control.

Beds.—Interpretation 1, issued May 23, to Order M-126 reads as follows: The item "Beds—except hospitals" appearing in Lists A and B of General Conservation Order M-126 is construed to include the following items: bunks, berths, metal folding cots, sanitary couches and day beds. It does not include the following items which, however, remain subject to the restrictions of General Limitation Order L-49: coil, flat, box and fabric bed springs (whether or not they are integral parts of beds or other sleeping equipment), innerspring mattresses and pads, and studio couches, sofa beds and lounges designed for dual sleeping and seating purposes.

Chemicals.—Amendment 1 to Order P-89, issued May 22, grants further priority assistance to chemical war industries. Placed under strict allocation are by-product ammonia, sulphate of ammonia, synthetic ammonia, cyanamid, capryl alcohol, isopropyl alcohol, methyl ethyl ketone, butyl alcohol and chemical cotton pulp.

Chlorate chemicals are placed under complete allocation control by General Preference Order M-171, issued June 1.

Construction.—Interpretation 1 to Order L-41 clarifies certain provisions of the order (see news article in this issue).

Cutlery.—Order L-140, effective May 30, sharply restricts the manufacture of tableware, pocket knives, scissors and other cutlery. The use of alloy iron or alloy steel in any of the articles covered by the order is prohibited. The only metals that may be used are unalloyed iron or steel, gold and silver.

Drapery, Upholstery and Floor Covering Fabrics.—Restrictions in the wool conservation order M-73 were relaxed on June 2 to permit manufacture of floor coverings, drapery and upholstery fabrics.

Electric Lamps and Shades.—Amendment 2 to Order L-33, issued May 25, redefines portable lamps and adds to the list of essential parts in which iron and steel may be used in the manufacture of lamps. The amendment clarifies the definition of portable lamps by excluding from the order any overhead suspended fixtures, either portable or nonportable.

Feathers.—Amendment 2 to Conservation Order M-102, issued June 1, makes uniform the restrictions on the use of duck and goose feathers for civilian purposes. Only feathers more than 4 inches in length may now be used to make civilian pillows and upholstery stuffing.

Fire Protective Equipment.—Amendment 3 to Order L-39, issued May 21, permits the manufacture of carbon dioxide extinguishers according to specifications of the armed services and Maritime Commission, restricting deliveries to orders rated A-1-j or higher.

Flashlights.—General Limitation Order L-71, amended June 5, permits flashlight manufacturers to use up inventories of plated iron and steel at a rate not exceeding their 1940 productions.

Fluorescent Fixtures.—Amendment 2, issued June 13, to Order L-78 releases from sales restrictions fluorescent lighting fixtures using tubes rated at 30 watts or less.

Foods.—Supplementary Order M-86-b, issued May 26, directs canners to set aside for the government their entire 1942 pack of salmon, sardines, Atlantic herring and mackerel.

Food Service Equipment.—Amendment 1 to General Limitation Order L-83, issued May 29, stipulates that coffee grinding machinery and food slicing and grinding machinery, the production and sale of which has been restricted, means machinery of 1 h.p. or over. Bakery machinery is likewise included in this classification. This amendment was necessary in order to distinguish between these types of machines and the small electrically operated types covered by Limitation Order L-65.

Industrial Machinery.—Order L-123, issued May 26, covers 14 types of industrial machines directed into war channels. Affected by this order is such machinery as passenger and freight elevators, electric motors of more than 1 h.p., industrial fans, industrial compressors and pumps. A preference rating of A-9 or higher is required for acceptance or delivery of such machinery.

Laboratory Equipment. — Metal laboratory equipment is prohibited except to replace essential existing equipment in laboratories affecting the public health, in government laboratories and to the extent necessary for repair parts and operating supplies for maintenance of existing essential equipment and activities in laboratories, by Order L-144 issued June 12.

Laundry Equipment.—Order L-91, as amended May 23, freezes commercial laundry equipment and places it under allocation control. The manufacture after May 15 of laundry equipment has been prohibited unless granted preference rating by W.P.B. Hospitals may buy used equipment or types not acceptable to the Army.

Light Bulbs.—Amendment 1, issued June 8, to Order L-28 curtails after July 1 the use of critical materials in the manufacture of elec-

to this exceptionally bland soap we added soothing lanolin

WHEN you see "Williams," you probably think of our shaving soap—which, of course, is one of the mildest soaps you can buy.

Now we are using this century-old "know-how" to make an extremely bland toilet soap. We add soothing lanolin to it—the same lanolin that is so often prescribed in emollient ointments.

In Williams Lanolin Soap uncombined alkali is virtually non-existent. No fatty acids are present. No dye. No strong perfume. The oils and fats are the finest we can buy, used generously, and in a way that precludes rancidity. We honestly don't know where you can find a gentler soap for a dry or irritated skin. Ideal for babies, too.

There's no "medicinal" appearance or odor to Williams Lanolin Soap. With its light fragrance, it appeals to patients as a fine toilet soap. For economy, each cake is subjected to extremely high pressure—it's an unusually *lasting* soap.

We'd like very much to send you a full-sized cake of Williams Lanolin Soap. That's much the best way to learn its advantages. Just send us your name and address. (You might send us your home address—then your family can enjoy it, too.) Use the convenient coupon, if you wish. There's no obligation, of course.

The J. B. Williams Co., Dept. SB-1
Glastonbury, Conn.

Gentlemen: I'll be glad to accept your offer of a full-sized cake of Williams Lanolin Soap.

Name_____

Street_____

City_____ **State**_____

tric light bulbs. This amendment does not curtail production of light bulbs themselves.

Mattresses.—Amendment 1, issued June 8, to Order L-49 prohibits after September 1 the production of mattresses or pads containing iron or steel. Hospitals are excepted, as we go to press.

Metal Office Furniture.—Wood filing cabinets containing not more than 2 pounds of essential steel hardware for each drawer have been removed (June 1) from the limitations of the Metal Furniture Order, L-13-a.

Office Machinery.—Order L-54-c, effective June 1, sharply curtailed manufacture of various types of office machinery and set up a system of distribution control so that only essential users may obtain the machines produced. Order L-54-b was revoked.

Plumbing and Heating.—Limitation Order L-79, as amended May 23, removes ban on metal plumbing and heating equipment necessary to civilian needs. Sale and delivery of any equipment on a preference rating of A-10, or better, are permitted. Among listed equipment which any person may sell and deliver is that specifically designed as hospital and surgical equipment.

Interpretation 1 to Order P-84, issued June 1, permits the installation of equipment calling for more material than that being replaced. Within the meaning of subparagraph (b) (3) of Preference Rating Order P-84, plumbing equipment or heating equipment which replaces the part or parts worn out, damaged or destroyed need not be identical with the part or parts replaced.

Schedule 12 to Order L-42 prohibits after June 20 use of metals other than joining hardware, coating or reenforcing mesh in a list of plumbing fixtures common in the home and commercial establishments.

Ranges and Stoves.—Limitation Order L-79, as amended May 23, permits sale of cooking and heating stoves and water heaters where no other equipment for these purposes is available. For electric ranges, however, application must be made on PD-1A for preference rating. An A-9 rating, or better, is required. The limitation on production specifically exempts items designed as hospital equipment.

Refrigerators.—Order L-5-d, effective June 15, supersedes the original freeze Order L-5-b and establishes rules for the disposition of some 600,000 domestic mechanical refrigerators now frozen in the hands of distributors and manufacturers. The new order sets up what is expected to be a permanent arrangement for the withdrawal from frozen stocks of refrigerators required for military and essential civilian needs.

Rubber Yarn and Elastic Thread.—Amendment 4 to Order M-124, issued May 26, prohibits use of bare rubber thread and of covered rubber thread of size 60 and coarser in manufacture of a list of health and medical products. Health products affected are repair cords and webs, sanitary belts, surgical elastic bandage, surgical stockings, trusses, webbing for respirators, hose masks, gas masks and inhalators, and surgical supports for abdomen, back and breast.

Safety Razors.—Order L-72-a, issued May 22, freezes sale and delivery of all safety razors in hands of manufacturers and jobbers except those in transit and those for the Army and Navy.

Steel and Iron.—Supplementary Order M-21-e, as amended May 16, limits the use of tin and terne plate to a few specific items except by authorization. Permitted uses include baking pans for institutions.

Telephone Service.—New telephone service is still available to preferred users, including those engaged in the maintenance of the public health, provided they can demonstrate that the service is necessary to discharge the essential activity in which they are engaged, by Interpretation 1 of Order L-50, issued June 2.

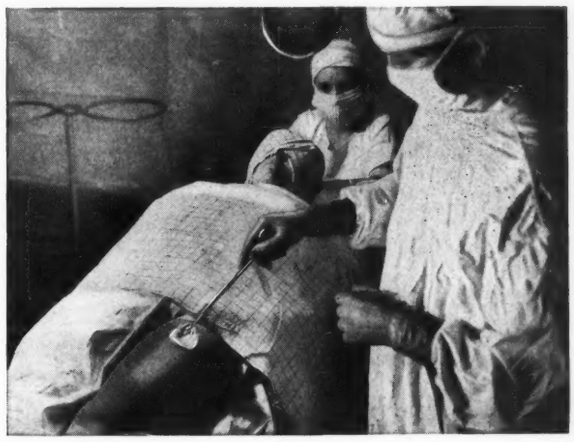
Tin.—Order M-43-a, as amended June 5, effective July 1, cuts the use of tin another 10 per cent in noncritical products.

Typewriters.—Amendment 2 to Order L-54-a, issued May 30, authorizes manufacturers to maintain their present rates of production during June and July.

U. S. I. Alcohol Assures Freedom from Aldehydes and Fusel Oil

To obtain the maximum freedom from aldehydes and fusel oil, U. S. I. Pure Alcohol must not only meet the strict U. S. P. standards for purity, but must also pass an even more exacting test devised in U. S. I.'s laboratories. A special reagent is added to the alcohol under examination, which causes a yellowish color to appear if even one part per million of aldehydes or fusel oil is present. Equally thorough tests assure the freedom of U. S. I. Pure Alcohol from every other type of harmful impurity—your guarantee of an alcohol with the highest quality.

Even a trace of harmful impurities in the alcohol used to sterilize the skin prior to an incision may lead to infection. To avoid this possibility, leading hospitals throughout the country use U. S. I. Pure Alcohol—just as they specify it for every application requiring the utmost in purity. Years of pure alcohol production are behind U.S.I. alcohol, years in which U. S. I. has developed methods for control and testing that are even more rigid than those of the U.S.P. For dependable results, use U.S.I. Pure Alcohol in laboratory, operating room and pharmacy.



Check your requirements for alcohol with this convenient list of 21 major hospital applications ...and specify U. S. I. Pure Alcohol for every use.

U. S. INDUSTRIAL CHEMICALS, INC.

60 EAST 42ND STREET, NEW YORK, N. Y.

A Subsidiary of U. S. Industrial Alcohol Co. • Branches in All Principal Cities

PURE ALCOHOL

CHECK LIST

21 IMPORTANT HOSPITAL USES FOR ALCOHOL

- ☐ Compounding Prescriptions
- ☐ Cresol Compounds Dilution
- ☐ Dehydration of Pathological Sections
- ☐ Drug Tincture & Extract Preparations
- ☐ Duodenal Drainage
- ☐ Floor Dressings and Packs
- ☐ Gastric Analysis
- ☐ Hand Rinsing After Scrub-up
- ☐ Hypodermic Injections
- ☐ Massage and Sponge
- ☐ Pharmaceutical Preparations
- ☐ Pharmacy Solvent for Vegetable Drugs
- ☐ Preserving Specimens
- ☐ Protein Precipitant
- ☐ Spirit Lamps
- ☐ Stains and Reagents
- ☐ Sterilizing Instruments
- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block

Senate Action Awaited on $3,500,000 Defense Training Bill for Nurses

WASHINGTON, D. C.—An appropriation of $3,500,000 for the "Training for Nurses (national defense)" has been approved by the House of Representatives and, if approved by the Senate, will be available for the fiscal year beginning July 1.

These funds, as during the past year, are being administered by the states relations division of the U. S. Public Health Service. They will be used for increasing the number of nursing students in basic programs, in preparing inactive graduate registered nurses for active service and in offering postgraduate instruction in special fields of study.

Eligible schools, offering basic nursing education programs, which cannot increase admissions but which could use grants for scholarship tuitions and for other entrance fees for students in financial need may apply for federal funds for this purpose. It is hoped that no qualified applicant in this country will be kept out of a school of nursing because of financial need.

Letters will be sent shortly to the schools throughout the country that are eligible to apply for funds for the various types of programs. Requests for application for these federal funds for the conduct of programs during the next federal fiscal year, beginning July 1, will be accepted by the U. S. Public Health Service immediately.

The three most acute bottlenecks in nursing education now, according to Pearl McIver of the U.S.P.H.S., are: qualified instructors and supervisors, qualified applicants and housing facilities for the increased number of students.

Voluntary Restriction of Conventions Is Requested

WASHINGTON, D. C.—Henry F. McCarthy, director of the division of traffic movement of the Office of Defense Transportation, is appealing to the public to cut travel to the minimum. No restrictions on individual railroad or bus travel have yet been issued, but Mr. McCarthy considers it a patriotic gesture to do as little traveling as possible.

Should restrictions become necessary, writes Mr. McCarthy, travelers will be given as much advance warning as possible.

As to conventions, no official order has been given but, as in individual travel, O.D.T. appeals to the public for support. This office does not want to attempt any travel rationing plan for the present. But in view of heavy military transportation, associations will be asked to cancel or curtail conventions whenever possible unless the meeting is directly connected with the war effort. No direct prohibition is anticipated soon. Many associations have already canceled plans for conventions.

New Hampshire Names Officers

New officers of the New Hampshire Hospital Association include the following: president, Fred A. Sharp, Margaret Pillsbury Hospital, Concord; vice president, Maude Miles, Peterboro Hospital, Peterboro; secretary, Anne C. MacDougall, Memorial Hospital, Nashua, and treasurer, Mabel L. Parsons, Elliot Hospital, Keene. Lillian G. Williams of Springfield, Mass., former superintendent of Laconia Hospital, was made an honorary member of the association.

Second Fund Appeal Also Success

Christian H. Buhl Hospital at Sharon, Pa., has just completed its second successful appeal for funds for increased capacity within a little more than two years. The more recent effort provides $300,000 for 104 additional beds, made necessary by intensified war effort throughout the Shenango Valley. Early in 1940, $145,000 was raised to pay for an addition completed at that time. Both campaigns were directed by Ketchum, Inc. of Pittsburgh.

Voluntary and Governmental Hospital Coordination Urged Upon New Yorkers

Greater coordination of all hospital interests to meet successfully the health needs of the nation was urged by Dr. Basil C. MacLean, president of the American Hospital Association, speaking before the eighteenth annual convention of the Hospital Association of New York State in Buffalo. Doctor MacLean pointed to the excellent results obtained in Great Britain through the cooperation of voluntary and governmental hospital interests as an example of what might be accomplished in this country. Progressive suggestions of the government should be considered in relationship to the establishment of a nonoperating but financial partnership, he believes.

Need for similar cooperation with public welfare departments was stressed by Lee C. Dowling, deputy state commissioner of social welfare, to provide adequate hospital care for relief cases.

The meeting of the hospital group was preceded by a conference of executives of Blue Cross hospital plans in which considerable discussion centered upon various proposed reciprocal arrangements among plans. Hope was expressed that before the year was over a suitable national scheme might be accomplished including the use of simplified procedures and forms for use in transferring clients from one plan to another.

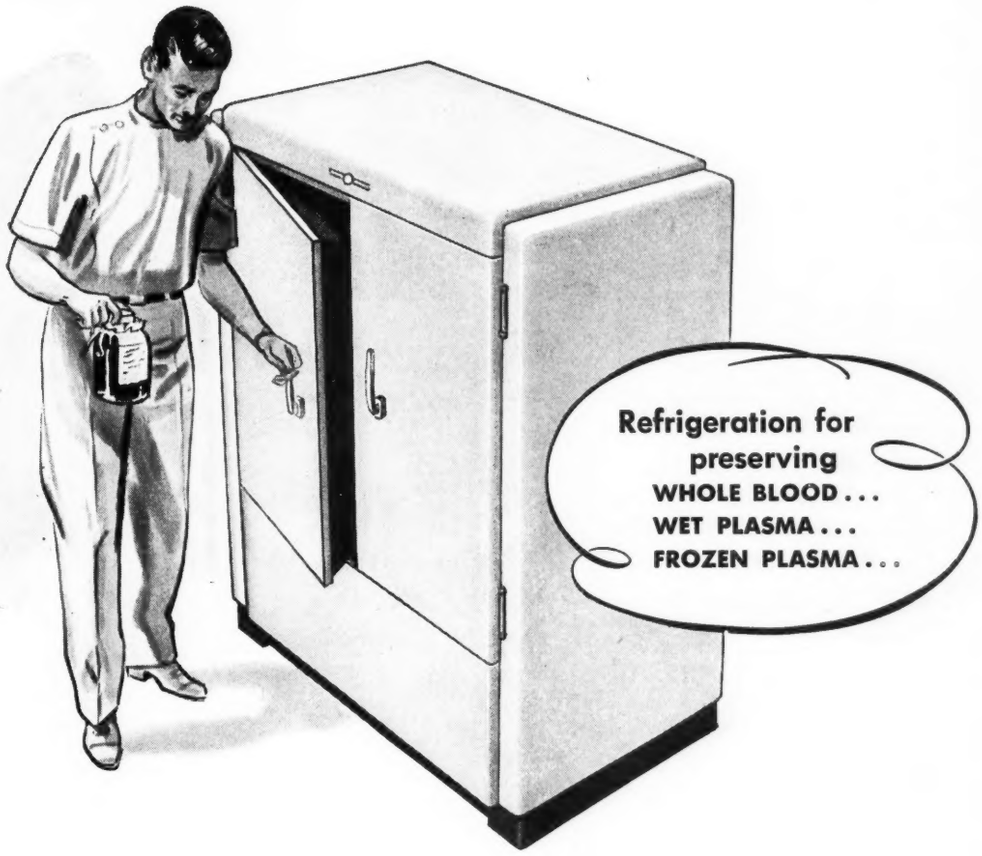
Hospital and health insurance constituted one of the major topics at the hospital sessions as well, many of the Blue Cross executives staying over to participate. Among the speakers were E. A. van Steenwyk of the Associated Hospital Service of Philadelphia and Charles C. Dubuar, principal actuary, State Insurance Department, Albany. Mr. van Steenwyk made a plea for more governmental aid from the federal level down to help pay for medical indigent patients. Less money spent over the 20 or 30 per cent of our population who need help but who are unable to enroll in Blue Cross plans would be more beneficial to hospitals, governmental units and individuals, he believes, than a considerably larger sum spread over the entire population regardless of individual need.

Among the answers to nursing problems were two constructive ideas presented by Doctor MacLean and Dr. Harvey Agnew, secretary, Department of Hospital Service, Toronto. Doctor MacLean suggested training soldiers as orderlies or hospital medical corps men to replace nurses in certain duties and revealed that the American Hospital Association has recommended to the Army that civilian hospitals be permitted to provide such training. Doctor Agnew indicated ways by which in the larger hospitals having plenty of interns the young doctors might relieve the nurses. In the smaller institutions, however, he believes that nurses might be used to relieve the current shortage of interns.

Dr. H. van Zile Hyde of the staff of Albany Hospital, a lieutenant-colonel of the U. S. Public Service, emphasized the lack of sufficient reserve units of plasma and urged eligible hospitals to apply for aid under the new federal grant for setting up or expanding blood banks.

Officers elected for the coming year are: Rev. John J. Bingham, Catholic Charities, New York City, president; Harold A. Grimm, superintendent, Millard Fillmore Hospital, Buffalo, first vice president; John F. McCormack, superintendent, Presbyterian Hospital, New York City, second vice president, and Austin J. Shoneke, superintendent, New Rochelle Hospital, treasurer. Trustees are Dr. Morris Hinenburg, Lee B. Mailler, Jerome F. Peck, Moir P. Tanner, Grace Hinckley and Dr. Leslie H. Wright.

Planning a Blood Bank?



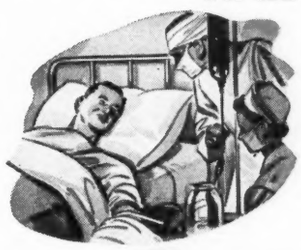
G-E experience – in scores of hospitals – goes back to the very beginning of blood storage

Just four years ago, establishment of Blood Banks made exciting news—holding hope for the saving of many lives by making possible transfusions without delay. General Electric refrigeration was used in these pioneering installations which—as you know—proved so successful that the idea has been adopted by hospitals all over the country.

G-E engineers are thoroughly familiar with the many technical problems involved in storing whole blood, wet plasma and frozen plasma. Their experience in this new field has been gained in planning installations for nearly a score of hospitals in New York City alone—for five in Philadelphia—and for many others from coast to coast.

You can count on G-E refrigeration equipment to give you the month after month dependability that is so essential in proper preservation of blood.

For full information on Blood Bank equipment for *your* hospital, consult your local G-E Dealer (look in the Classified section of the Telephone Directory) or write to General Electric, Division 2677, Bloomfield, N. J.



GENERAL ELECTRIC

Nursing Deputies for Civilian Defense Are Urged by Baehr

WASHINGTON, D. C.—Dr. George Baehr, chief medical officer of O.C.D., urged regional directors last month to appoint a nurse deputy to the chief of Emergency Medical Service.

A nurse with organizing ability, time and ability to take the responsibility for recruiting nurses for active duty with the Emergency Medical Service should be selected. Each state and local chief of Emergency Medical Service is also advised to make such an appointment after he has consulted the state or local nursing council. The person appointed should thereafter be a member of the nursing council.

The duties of the state nurse deputy are: to assist the state chief of Emergency Medical Service and the local nurse deputies in the state in mobilizing all members of the nursing profession for duty in the Emergency Medical Service during and after an enemy attack or other war-time disaster; to aid the American Red Cross and the hospitals to carry through a full program of training of nurses' aides; to assist the state hospital officer and state chief of Emergency Medical Service in the emergency assignment of private duty nurses and of nurses from local and state hospitals and health agencies to base hospitals if the need arises.

The duties of the local nurse deputy are: to maintain an active file of available nurses; to provide all nurses with a first-aid course and instruction on gas protection and the care of chemical casualties (these particular duties are to be carried out in collaboration with the American Red Cross and the local chief of Emergency Medical Service); to arrange with local agencies employing public health nurses for home visits to casualties, slightly injured, and convalescent patients discharged early; to assist the local chief of Emergency Medical Service in arranging for centralized reporting of the need of this nursing care in the homes; to assist the local chapter of the American Red Cross and the local hospitals to carry through a full program of training of nurses' aides.

Iowa Association Names Leaders

The destinies of the Iowa Hospital Association will be guided for the next year by the following officers: president, A. L. Langehaug, Lutheran Hospital, Fort Dodge; first vice president, Paul Hanson, Lutheran Hospital, Des Moines; second vice president, Sr. Mary Magdalene, St. Joseph's Hospital, Ottumwa; secretary, Orville Peterson, Eldora Memorial Hospital, Eldora; treasurer, Phil Hutchinson, Broadlawns Hospital, Des Moines; new trustees, T. P. Sharpnack, Broadlawns Hospital, and R. J. Connor, University Hospitals, Iowa City.

Heads Chicago Administrators' Section

Rev. Joseph A. George, administrator of the Evangelical Hospital, has been chosen chairman of the administrators' section of the Chicago Hospital Council to succeed Clinton F. Smith, who has moved to St. Louis. Dr. Roger W. DeBusk is the new vice chairman, Clarence T. Johnson is secretary and Dr. Otis D. Whitecotton and Mabel Binner are new members of the executive committee.

Will Collect for U.S.O.

The Associated Hospital Service of Philadelphia, as a public service, has volunteered to make collections for the U.S.O. in those plants in which the local campaign organization cannot otherwise make collections because of governmental regulations.

Legionnaires Give Sterilizer

The American Legion post at Brownsville, Pa., recently presented Brownsville General Hospital with a dressing sterilizer, a loading car of the cradle type and three dressing drums, purchased at a cost of $1320, Mrs. L. S. Knuth, superintendent of the hospital, reports.

Executive Housekeepers to Buy Ambulance; Miss Pearse Is New President

Members of the National Executive Housekeepers' Association will participate in "housekeeping week" during the first week in October when the chapters will raise funds for the purchase of an ambulance which is to be presented to the government, it was resolved at the biennial conference of the N.E.H.A. held at Detroit, June 4 to 7. The N.E.H.A. ambulance will be exhibited during the week of the national hotel exposition at Grand Central Palace, New York City on November 9 to 13.

Delegates to the conference also voted to confer associate membership upon assistant housekeepers in hotels of 500 rooms or more and hospitals of 500 beds upon the recommendation of their superiors.

A highlight of the program was the broadcast on "The Housekeeper" made by Mrs. Doris L. Dungan, retiring president of the association, and executive housekeeper at Hartford Hospital, Hartford, Conn., over the Canadian station CKLW.

New officers elected for the ensuing two years included Camilla Pearse, Hotel Prenford, Detroit, president; Lillian Bohart, Forest Park Hotel, St. Louis, first vice president; Alice Eldridge, Fairmont Hospital, San Leandro, Calif., second vice president, and Ethel M. Schneider, Nicollet Hotel, Minneapolis, recording secretary.

Mrs. Alta M. LaBelle, housekeeping director of Michael Reese Hospital, Chicago, and retiring president of the Chicago chapter, was elected to the board of directors for a four year term.

Plan Now for Postwar Needs

Detailed plans for future inevitable expansion should be made now to eliminate inefficiencies following the present emergency. Consideration also should be given to raising funds for such purposes. Such thinking and planning appear more logical to members of the Northwest District Hospital Association of Pennsylvania than attempting to accomplish building programs under present restrictions. At a recent meeting in Erie, the group also expressed the belief that federal financing should be avoided, if possible. Alma Troxell, superintendent, Oil City Hospital, was elected president and Margaret Bower, superintendent, Community Hospital, was re-elected secretary.

Hartford Hospital Seeks Five Million

The sum of $5,000,000 is being sought for a 15 story building for Hartford Hospital, Hartford, Conn. A six story unit, now under construction, will be devoted principally to maternity service, although an extensive out-patient department will also be housed in it. The south wing clinic on the ground floor will be used as emergency disaster quarters during the war. Coolidge, Shepley, Bulfinch and Abbott of Boston are the architects and Will, Folsom and Smith, Inc., of New York are the public relations' and fund-raising counsel.

Will Teach Kenny Technics

Courses for physicians, nurses and physical therapists in the Kenny method of treating infantile paralysis are now available at the University of Minnesota, Minneapolis. A six day physicians' course starts July 6 and August 10. The course for hospital nurses, also six days, starts July 13. A two to six months' course for registered physical therapy technicians is also open to nurses sponsored by teaching hospitals and public health services. Applicants will be notified when the new courses will begin.

Request for Convalescent Care

Touro Infirmary has received a bequest of $300,000 for the erection of a memorial pavilion for convalescent patients. The bequest is from the estate of the late Emanuel Weil.

Community Chest for New York City Urged by Newbold Morris

To prevent any possible collapse of private philanthropy in New York City, a community chest to replace individual appeals was recommended by Newbold Morris, president of the city council, at the annual meeting and luncheon of the Greater New York Hospital Association. Such a program would net a larger number of subscriptions through reaching a larger number of individuals.

Committees are being formed to consider the possibilities of either relieving the city of some financial burden or granting it additional powers of taxation. This would release approximately $200,000,000, some of which can be diverted to the relief of hospitals.

During the business session the following officers were elected: Bernard McDermott, superintendent, Long Island College Hospital, president; John H. Hayes, superintendent, Lenox Hill Hospital, first vice president; Dr. Morris Hinenburg, director, Jewish Hospital of Brooklyn, second vice president; William B. Seltzer, superintendent, Bronx Hospital, secretary, and George F. Holmes, head of Memorial Hospital, treasurer.

The executive committee includes the Rev. J. J. Curry, Max DeKaye, Doctor Hinenburg, Mr. Holmes, James U. Norris, the retiring president, John H. Olsen, the Rev. C. O. Pedersen, Mr. Seltzer and Dr. Joseph Turner.

Campaign Goes Over in Three Weeks

A three week period of local solicitation for St. Ann's Maternity Hospital, Cleveland, resulted in an oversubscription in a $400,000 campaign. As a result, the Sisters of Charity of St. Augustine will have a new hospital unit and extensive repairs will be made to the Loretta House for unwed mothers and the Baby House for foundlings and orphans. New construction will increase the capacity of the maternity hospital to 100 beds. Ketchum, Inc. of Pittsburgh directed the financial campaign.

Arkansas Association Elects Officers

John F. Dudley of Baptist Hospital, Little Rock, Ark., will head the Arkansas Hospital Association for the coming year. Other officers named at the annual meeting on May 15 are as follows: president-elect, V. A. Snyder, Trinity Hospital, Little Rock; vice president, Ruth Beall, Arkansas Children's Home and Hospital, Little Rock; secretary-treasurer, Florence Reese, Sparks Memorial Hospital, Fort Smith; new trustees, William O. England of Wakenight Hospital, Searcy, and V. A. Snyder.

Psychiatric Center Is Dedicated

One of the world's greatest centers of research and training in nervous and mental diseases, the Illinois Neuropsychiatric Institute, Chicago, was dedicated on June 6.

Coming Meetings

July 7-8—Hospital Associations of Nova Scotia, Prince Edward Island and New Brunswick, Pictou Lodge, Pictou, N. S.

Aug. 17-21—National Medical Association, Cleveland.

Aug. 24-28—American Dental Association, Boston.

Sept. 9-12—American Congress of Physical Therapy, Hotel William Penn, Pittsburgh.

Sept. 14-26—A.H.A. Institute for Hospital Administrators, International House, University of Chicago, Chicago.

Oct. 12-16—American Hospital Association, St. Louis.

Oct. 19-22—American Dietetic Association, Detroit.

Oct. 19-23—American College of Surgeons, Hospital Standardization Conference, Stevens Hotel, Chicago.

Oct. 26-31—American Public Health Association, St. Louis.

Nov. 5-6—Maryland-District of Columbia Hospital Association, Carvel Hall, Annapolis, Md.

1943

Feb. 18-19—Texas Hospital Association, Texas Hotel, Fort Worth.

March 10-12—New England Hospital Assembly, Hotel Statler, Boston.

April 14-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.

10,700 Nurses, Many in Uniform, Meet in War-Time Convention

The tang of Army and Navy uniforms and the intensity of their war-time task infiltrated throughout the 10,700 nurses who met in Chicago the week of May 18 in the biennial convention of the three national nursing organizations. Claribel A. Wheeler of the National League of Nursing Education was general chairman of this stirring and smoothly running convention.

Precedent was smashed when the coveted Saunders Medal bestowed biennially on an outstanding and often venerable figure in nursing was split—or rather duplicated—and presented to two predominantly young and vigorous groups, the Army and Navy Nurse Corps. Col. Julia O. Flikke accepted the medal for the Army corps and Mary D. Touse for the Navy.

Columnist Walter Lippmann told the Red Cross session that "the first essential to winning the war is to realize that what really matters is not material possessions or social or professional status, but knowledge, acquired skill, an honest character and a brave soul. When we accept that tenet, we can accept rationing, taxes, loss of luxuries and other restrictions with equilibrium."

Educator George F. Zook sees in the war-time federal appropriation of $1,200,000 for nursing education a possible precedent for postwar federal contributions.

T. V. Smith, the philosopher and politician, fitted the nurses into his program for the defense of democracy, a three-fold program based on truth (science), beauty (art) and goodness (politics).

Federal Grants for Blood, Plasma Banks Are Extended

The restrictions on federal grants for aid in establishing blood and plasma banks may be relaxed on July 1 to permit such grants to hospitals more than 300 miles from the Atlantic, Pacific or Gulf coasts, according to announcement last month by the medical division of O.C.D. Technical manuals on blood and plasma banks are now available.

A new sound slide film on the operation of the Emergency Medical Service was released last month by O.C.D. The film shows the integration of the medical activities with those of other protective services during an air raid or other war disaster.

Bulletin No. 4 on "Central Control and Administration of Emergency Medical Service" was issued recently by O.C.D. It shows the relationship of the Emergency Medical Service to the control system of the citizens' defense corps and the civil air-raid warning system. Another recent bulletin deals with the treatment of burns and prevention of wound infections, emphasizing the early use of crystalline sulfanilamide.

O.C.D. announces that hydrogen peroxide is entirely ineffective as a treatment for Lewisite burns of the eyes. Washing with large amounts of a 2 per cent solution of sodium bicarbonate in water or with plain water is the most effective treatment and should be carried out as soon as possible after exposure.

"Protect Community Health"

WASHINGTON, D. C.—Six high federal officials appealed last month to war production drive committees to speed production and to "use your influence to see that your community has an active public health department and enough doctors, nurses and hospital beds to care for your workers and their families." The appeal was signed by Donald M. Nelson, Paul V. McNutt, Robert P. Patterson, James V. Forrestal, E. R. Stettinius Jr. and E. S. Land.

St. Luke's Votes for Ward Plan

The board of managers of St. Luke's Hospital has voted to participate in the Community Ward Plan, the seventy-first hospital in the New York metropolitan area to make the decision.

Named Officers in Louisiana

Newly elected officers of the Louisiana Hospital Association are as follows: president, R. E. Blue, Tri-State Hospital, Shreveport; president-elect, Mrs. Kate Tipping, Touro Infirmary; secretary-treasurer, A. P. Richard, Hotel Dieu, New Orleans; trustees, Graham Price, R.N., Alexandria, and Dr. A. J. Hockett, Touro Infirmary.

Quinine Order Is Tightened

Sale of all stocks of quinine and totaquine is now restricted by order M-131 as amended on June 19. Formerly stocks of less than 50 ounces were exempt. A new order, M-131-a, prohibits the sale of any amount of cinchonine or cinchonidine for other than anti-malarial purposes or the sale of quinidine except for anti-malarial or cardiac uses. Also on June 19, O.P.A. relaxed the rules on sugar to give more if needed.

Chicago Hospital Closes Doors

Washington Boulevard Hospital, Chicago, a 100 bed institution opened in 1913, will discontinue admitting patients on June 30. The medical staff has accepted an invitation to join the staff of Wesley Hospital. The nursing school also will be transferred to Wesley and will reopen in September. Dr. Arthur R. Metz is president of Washington Boulevard Hospital and Clarence T. Johnson is administrator.

Says Federal Taxes Threaten Life of Voluntary Hospitals

Warning that federal taxes threaten the continued existence of voluntary hospitals and educational institutions was voiced before the Catholic Hospital Association's annual convention in Chicago on June 15 to 19.

William F. Montavon, director of the legal department of the National Catholic Welfare Conference, stated that hospitals are jeopardized by: (1) the requirement that they fill out form 990 on their income and disbursements which provides no way of indicating charity service; (2) Secretary Morganthau's recommendation that they be made subject to a tax on income derived from a trade or business not directly related to its tax-exempt activities; (3) imposition of excise taxes on articles used by voluntary hospitals although such taxes are not imposed on governmental hospitals rendering like service, and (4) the recent Treasury ruling that part of the income of "big name" performers arising from a special event for charity must now be taxed, though previously exempt.

Sister Francis Clare of Hays, Kan., was added to the executive board at the business session, all of the present officers being reelected.

Purchasing Institute Was Practical

Fifty persons either wholly or partially interested in the purchasing function attended the second institute on hospital purchasing held at the University of Michigan, June 1 to 5, under A.H.A. auspices. "Members of the institute discovered anew that salvage and saving along with conservation are the keys to today's purchasing. They discovered that rationing of everything from gasoline to canned goods was either a reality or a definite possibility," Paul L. Burroughs reports.

To Guide Kentucky Association

The Kentucky Hospital Association at its annual assembly named the following officers: president, Frieda Dieterichs, Owensboro; president-elect, Rev. Thomas Ashley, Pikeville; first vice president, Sister Alocogue, Covington; second vice president, Gladys Echols, Louisville; treasurer, H. L. Dobbs, Louisville; executive secretary, H. A. Cross, Louisville.

Holds Institute for Record Librarians

An institute for medical record librarians will be given in Durham, N. C., July 13 to 15, sponsored by Duke University Medical School and Hospital and the Duke Medical Record Librarians' Alumnae Association.

Names in the News

Administrators

Carl I. Flath

CARL I. FLATH, assistant director of Michigan Hospital Service for the last three years, has accepted the position of administrator of the Charlotte Memorial Hospital, Charlotte, N. C. Mr. Flath succeeds FRED M. WALKER, whose resignation becomes effective July 1. Mr. Flath is a Canadian by birth.

HOMER WICKENDEN has been appointed director of New York Medical College, Flower and Fifth Avenue Hospitals, succeeding DAVID Q. HAMMOND, whose resignation was recently announced. Mr. Wickenden was formerly associated with the United Hospital Fund.

ROBERT W. BACHMEYER, assistant to the director of the New York Society for the Relief of the Ruptured and Crippled, resigned his position June 15 to serve in the hospital division of the Office of Civilian Defense.

MELIDA AMLI, formerly superintendent of Community Hospital, Big Rapids, Mich., has been appointed supervisor of the hospital department of Michigan Hospital Service, Detroit.

A. ROSENBERG, formerly assistant director of the Hospital for Joint Diseases, New York City, has been named administrator of the hospital, DR. J. J. GOLUB, director, announces.

E. M. JONES has been appointed superintendent of the Dorchester County Hospital, Summerville, S. C., succeeding HAROLD F. WEBER who has been named assistant superintendent of Roper Hospital, Charleston, S. C.

DR. WILLIAM I. POTTS, assistant superintendent of Worcester County Sanatorium, has resigned his position to become superintendent of the Hillsborough County Sanatorium, Tampa, Fla.

MARY JEAN AUFDERHEIDE, superintendent of Schneck Memorial Hospital, Seymour, Ind., has announced she will resign her position to enter the Army Nursing Corps. As soon as Miss Aufderheide receives orders to report for duty, her position at Seymour will be taken over by MRS. H. H. CARTER.

BRIG. GEN. OMAR H. QUADE has been assigned to command at Fitzsimons General Hospital, Denver.

MARY SKEOCH, formerly superintendent of St. Luke's Hospital, Marquette, Mich., is now associated with the American Hospital in Britain, Headington, Oxford, England.

DR. F. S. SALISBURY has been named head of the Veterans Administration Facility, Knoxville, Iowa, filling the vacancy left by the death of DR. GEORGE R. STALTER.

GERTRUDE G. REYNOLDS, R.N., formerly assistant superintendent of Mary A. Alley Emergency Hospital, Marblehead, Mass., has been named superintendent of the hospital.

THADDEUS J. MONTGOMERY, formerly assistant superintendent and business manager of Cincinnati General Hospital, was appointed administrator of the hospital succeeding HENRY N. HOOPER, who is serving in the hospital division of the Office of Civilian Defense.

THELMA B. WARD has succeeded MRS. EUDA W. BRAND as superintendent of Riverside Hospital, Paducah, Ky.

HARRIET MCAFEE has been appointed superintendent of Haywood County Memorial Hospital, Brownsville, Tenn., succeeding MRS. CHARLOTTE LAWSON, who is the new superintendent of Rutherford Hospital, Murfreesboro, Tenn.

Mrs. Gladys McClain has been named superintendent of the Nobles Memorial Hospital, Paris, Tenn. Mrs. McClain succeeds Mrs. Pauline Haskins as superintendent of the hospital.

DeWitt Wright, formerly superintendent of the Marlboro County General Hospital, Bennettsville, S. C., has been appointed assistant superintendent of the Norfolk General Hospital, Norfolk, Va. E. A. Kelley, R.N., is the new superintendent of the Marlboro County General Hospital.

J. J. Loughlin Jr. has been named business manager of the Dr. J. Arthur Dosher Memorial Hospital, Southport, N. C.

B. B. Bobo has assumed his new duties as business manager of St. Luke's Hospital, Tryon, N. C.

Gertrude M. Watson, superintendent of Strathroy General Hospital, Strathroy, Ont., resigned her position effective July 1.

Olive Waterman, R.N., formerly superintendent of Alexandra Marine and General Hospital, Goderich, Ont., has been named superintendent of nurses at McKellar General Hospital, Fort William, Ont.

Dr. William E. Hudson has submitted his resignation as superintendent of the Tuscarawas County Tuberculosis Sanatorium, New Philadelphia, Ohio. Doctor Hudson has been head of the institution since it was opened in 1937.

Department Heads

Mary E. Heyward, formerly assistant director of nurses at Ellis Hospital, Schenectady, N. Y., has been appointed director of nurses at the Brockton Hospital, Brockton, Mass.

Grace E. Dick, first assistant superintendent of nurses, and Margaret E. Currens, operating supervisor, both of Charleston General Hospital, Charleston, W. Va., have resigned their positions to enter active Army service.

Mrs. Charles G. Page, executive housekeeper at Henrotin Hospital, Chicago, has resigned her position because of ill health.

H. Louis Wilson, former business manager of Ware County Hospital, Waycross, Ga., will manage the new Floyd County Hospital, Rome, Ga.

Miscellaneous

Dr. Robert P. Fischelis, secretary and chief chemist of the board of pharmacy of New Jersey, was awarded the honorary degree of Doctor of Science at the commencement exercises of the New Jersey College of Pharmacy of Rutgers University.

John W. Rankin, formerly associated with the Duke Endowment, is serving as special consultant for the U. S. Public Health Service in the fourth regional office of Civilian Defense.

Eldon S. Lazarus, president of the board of managers of Touro Infirmary, New Orleans, has succeeded Charles I. Denechaud as president of the Hospital Service Association of New Orleans.

John L. Beard, a member of the enrollment staff of the Minnesota Hospital Service Association, recently assumed the responsibilities of enrollment director for the organization.

Deaths

Dr. J. M. Finney, professor emeritus of surgery at Johns Hopkins University since 1933, died on May 30 after a long illness. In 1913 Doctor Finney was elected the first president of the American College of Surgeons; he was chief consultant in surgery for the A.E.F. in France during the first World War. At the time of his death, Doctor Finney held the rank of brigadier general in the United States Army Reserve Corps.

Dr. Edwin H. Coward, medical director and superintendent of the Atlantic County Hospital Almshouse, Northfield, N. J., died suddenly on June 10. Doctor Coward was graduated by the Jefferson Medical College in 1913 and served his internship at St. Mary's Hospital, Philadelphia.

Books on Review

INSECT PESTS. *By William Clunie Harvey, M.D., and Harry Hill. Brooklyn, N. Y.: Chemical Publishing Company, Inc.* 1941. *Pp.* VII+292. $4.25.

Be the hospital buildings new or old, vermin prevention or vermin control is ever a management problem.

While we all know of suitable chemicals to use for various types of pest nuisances, we may find our time wasted and our efforts misdirected unless we are aware of the habits, life history and environments of the insect in question. It would, therefore, behoove everyone who is in charge of this phase of hospital administration to read this new book of skilled procedures and scientific methods of vermin control.—A. M. LABELLE.

THE MARCH OF MEDICINE. *No. VI of the New York Academy of Medicine Lectures to the Laity. New York: Columbia University Press,* 1941. *Pp.* 154. $2.

This series of lectures is designed to outline the history of medicine and to orient for the layman the place of medicine in the social and cultural order of modern life. While they require no technical vocabulary in order to be understandingly read, the lectures should prove intensely interesting to the physician. Indeed, two of them are addressed to the physician: "Humanism and Science" and "Philosophy as Therapy."

The other lectures cover a variety of subjects: "Paracelsus," "Psychiatry and the Normal Life," "The Promise of Endocrinology" and "What We Know About Cancer." Each of these may be as profitably read by the physician as by the layman. — CHARLES ALEXANDER JONES, M.D.

THE HISTORY OF PUBLIC WELFARE IN NEW YORK STATE 1867-1940. *By David M. Schneider, Ph.D., and Albert Deutsch. Chicago: The University of Chicago Press,* 1941. *Pp.* 410. $3.50.

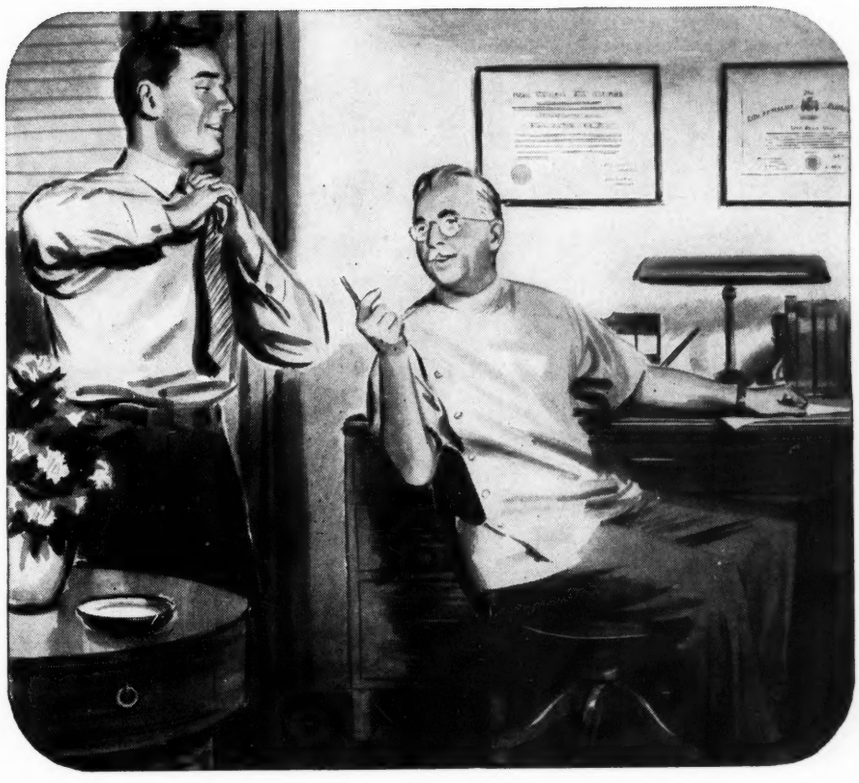
In 1938, the University of Chicago Press published "The History of Public Welfare in New York State, 1609-1866" by David M. Schneider. Now appears a companion volume bringing this historical account down to 1940 in whose authorship Albert Deutsch collaborates with Doctor Schneider.

The book bears the imprint of scholarship and painstaking industry on the part of its authors. In one respect it lacks a desirable completeness in that it deals with only such aspects of public welfare as come under the supervision of the state board. The book is illustrated and particularly well documented. — JOHN E. RANSOM.

FIRST AID PRIMER. *By Herman Leslie Wenger, M.D., and Eleanora Sense, M.Sc. New York: M. Barrows & Company, Inc.,* 1942. *Pp.* 104.

This book is written for the civilian who wants information on how to conduct himself in the emergencies arising from this war.

Pithy advice is given to the general public on taking care of itself. Good counsel as to what to do about feeding and what to do in case a community is faced with the feeding of large numbers of destitute people is pertinent to the time. There is a brief chapter on blackouts and a particularly sensible discussion on morale through nutrition. It is well written and well serves the purpose for which it was prepared.—B. W. BLACK, M.D.



QUESTION: *Canned meats are all right for supplying proteins, but how about vitamins?*

ANSWER: Fresh lean meats are important sources of the factors in the "vitamin B complex." With the exception of thiamin (vitamin B_1) these vitamins are little affected by heat treatments used in cooking or canning meats. Although losses of thiamin occur during cooking or canning, certain meats cooked or canned are important dietary sources of the factors in the "vitamin B complex" especially of riboflavin and niacin. (1)

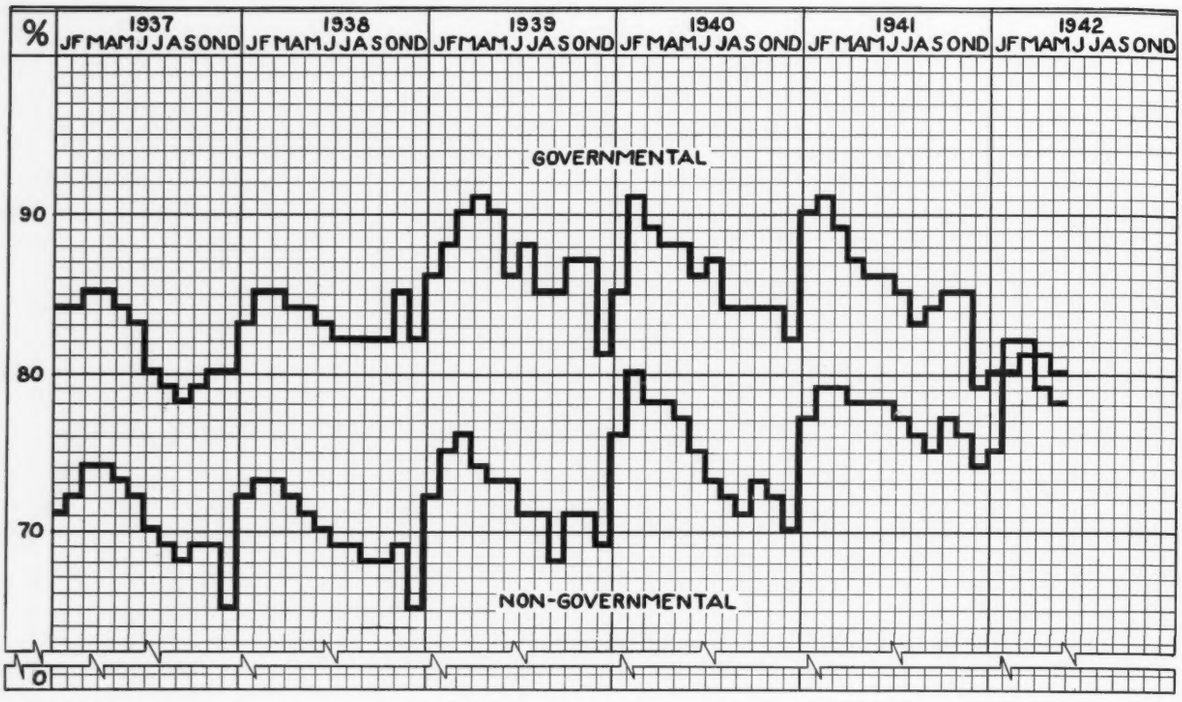
American Can Company, 230 Park Avenue, New York, N. Y.

---

(1) 1934, U. S. Pub. Health Reports 49, 754.
1939, J. Nutrition 17, 269.
1939, Ibid 18, 517.
1942, J. Am. Dietet. Assn. 18, 145.

The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

Occupancy Shows Usual Seasonal Drop



Occupancy in voluntary general hospitals in May dropped slightly from the April level but equaled the figure for May 1941. In the governmental hospitals there was also a slight reduction from April but a sharp drop from May 1941.

Twenty-six new construction projects were reported from May 18 to June 15, with values for 23 of them totaling $7,100,000. Few of these were Lanham Act projects. This brings the total value since January 1 to $81,300,000 as compared with $59,700,000 for the same period of last year.